REPORT OF THE
BOARD OF DIRECTORS OF THE
COOK COUNTY HEALTH AND HOSPITALS SYSTEM

JULY 23, 2008

ATTENDANCE

Present: Chairman Warren L. Batts; Vice Chairman Jorge Ramirez and Directors David A. Ansell, MD, MPH; Hon. Jerry Butler; David Carvalho; Quin R. Golden; Benn Greenspan, PhD, MPH, FACHE; Sister Sheila Lyne, RSM; Luis Munoz, MD, MPH; Heather E. O'Donnell, JD, LLM; and Andrea Zopp (11)

Absent: None (0)

Also Present: Eileen Couture, MD – Chief Medical Officer, Cermak Health Services; Matthew B. DeLeon – Secretary to the Board of Commissioners of Cook County; Patrick T. Driscoll, Jr. – Deputy State's Attorney, Chief, Civil Actions Bureau, Office of the State's Attorney; Avery Hart, MD – Chief, Division of General Medicine and Primary Care, Stroger Hospital of Cook County; Maurice Lemon, MD, MPH – Chief Medical Officer, Stroger Hospital of Cook County; Elizabeth Reidy - Deputy Chief, Civil Actions Bureau, Office of the State's Attorney; David Small – Chief Operating Officer, Cook County Bureau of Health Services

Ladies and Gentlemen:

Your Board of Directors of the Cook County Health and Hospitals System met pursuant to notice on Wednesday, July 23, 2008 at the hour of 7:30 A.M. at 1900 West Polk Street, Student Lounge, in Chicago, Illinois.

Your Board of Directors has considered the following items and upon adoption of this report, the recommendations follow.

Matthew B. DeLeon, Secretary to the Board of Commissioners of Cook County, called the roll of members and it was determined that a quorum was present.

APPROVAL OF MINUTES

Approval of the minutes of the meeting of the Cook County Health and Hospitals System Board of Directors of Friday, July 11, 2008 at 7:30 A.M.

Director Ansell, seconded by Director Butler, moved to approve the minutes of the meeting of the Cook County Health and Hospitals System Board of Directors of Friday, July 11, 2008.

Director Carvalho noted that on pages eight and nine of the report, reference is made to the Illinois Department of Public Health. The correct entity that should be referenced instead is the Illinois Department of Human Services.

Chairman Batts stated that the correction would be duly entered on the record.

On the motion to approve the minutes, as amended, a voice vote was taken and THE MOTION CARRIED UNANIMOUSLY.

REPORT FROM THE SYSTEM CHIEF OPERATING OFFICER

David Small, Chief Operating Officer of the Bureau of Health Services provided the Board with information and updates on several issues.

Mr. Small informed the Board of the planned resignation of Cermak Health Services' Chief Medical Officer, Eileen Couture, MD. Dr. Couture will be replaced by Avery Hart, MD, who is currently the Chief of the Division of General Medicine and Primary Care at Stroger Hospital of Cook County.

Dr. Hart introduced himself to the Board and provided a brief summary of his background.

Mr. Small added that Dr. Hart would serve as Interim Chief Medical Officer until the medical staff at Cermak Health Services starts the formal process through their own bylaws to form a committee for the recommendation and selection of a permanent Chief Medical Officer.

With regard to revenue cycle activity, Mr. Small informed the Board that there may be a cash acceleration of possibly more than $7 million. MedAssets has identified several areas that could contribute to this, such as identifying potential Medicaid eligibility from the self-pay population and aggressive targeting of accounts past due more than 150 days.

Mr. Small stated that information would be brought before the Finance Committee within its next two meetings regarding aged receivables recognized in audits as bad debt, and for which has been fully reserved.

Mr. Small informed the Board that financial information from the County as of May 2008 had not yet been received. He added that the Bureau did not have a suitable general ledger system. He stated that a review of available existing systems would be done, after which a recommendation would be made to the Board in order to migrate from the hodge-podge of systems currently used by the Bureau.

Mr. Small indicated that two documents had been distributed to the Board. One was a memorandum with regard to recruitment efforts from Cecil Marchand (Attachment #1), and the other was information relating to Federal and State financial pressures and opportunities for the System (Attachment #2).

Mr. Small informed the Board that through negotiations at the state and federal level with regard to a regional bed tax plan, a potential $86.5 million may come to the County, if a state plan amendment submitted to the federal government is passed.

In response to Director Ansell's question of whether this potential revenue would be part of the revenue projections for fiscal year 2009, Mr. Small responded that he would strongly recommend against including this revenue as part of those projections.

Director Ansell requested that further information and updates, including operational dash boards, be provided to the Finance Committee on a monthly basis.

Mr. Small responded that these reports are currently being developed, and would be ready for their review sometime in August.

REPORT FROM THE SYSTEM CHIEF OPERATING OFFICER (Continued)

In response to Director Greenspan's request for a summary of the agreement with MedAssets and a report on their performance, Mr. Small responded that a report tracking their performance, workplan and milestones was being created, and that the revenue cycle committee would monitor their progress. He added that the revenue cycle committee was composed of himself, Cook County's Chief Financial Officer Donna Dunnings, Cook County's Chief Information Officer Antonio Hylton, and other key individuals. The committee is designed to meet every two weeks.

Director Carvalho inquired into the subject of enrollment and eligibility issues. He asked for an update on current processes with regard to vendors currently engaged.

Mr. Small responded that the contract specifications for the current vendors require a certain level of performance, however the MedAssets assessment indicates that the performance levels, due to various reasons, are uneven and inconsistent.

Director O'Donnell requested a summary on the services being provided by the current vendors with regard to progress and benchmarks, and information on how these services will be integrated into the MedAssets contract.

Mr. Small replied that he would provide the information.

Director Carvalho requested that the Board receive copies of a letter from Mr. Small to the Centers for Medicare and Medicaid Services (Attachment #3) which delineated the negotiations previously mentioned with regard to the $86.5 million. He asked whether this potential revenue would be earmarked only for the Health and Hospitals System or whether there would be subsequent negotiations with the County in terms of what portion the System would receive.

Mr. Small responded that there has been no other indication to contradict the belief that 100% of these dollars would go to the Health and Hospitals System. The nature of dollars to aid the uninsured would dictate the use of the dollars in this manner.

In response to Director Carvalho's concerns whether the level of funding through County tax dollars would be affected if this potential revenue is received by the System, Mr. Small responded that the System would still need the full level of current funding through County tax dollars. Mr. Small added that the fiscal year 2009 personnel expense is expected to increase by $70 million due to collective bargaining agreements.

Director O'Donnell inquired whether the $86.5 million was a gross or net amount, and whether the State would receive a portion of the amount.

Mr. Small replied that due to specific calculations included in the plan, if there was a significant drop in the System's Medicaid volume or a significant change in the cost to deliver care, this would impact the amount.

OLD BUSINESS

DISCUSSION AND ADOPTION OF SYSTEM BOARD RULES

Chairman Batts noted that the Board had previously received the proposed System Board Rules for their review. (See Attachment #4.)

Elizabeth Reidy, Deputy Chief of the Civil Actions Bureau of the Office of the State's Attorney, stated that the document before them included all of the proposed changes received from the Directors. She stated that the Board could either go through all marked changes one by one and vote them up or down individually, or she could provide an overview of four issues identified within the proposed System Board Rules where there are alternative suggestions or further clarification is needed.

Director Zopp, seconded by Director Butler, moved to have Ms. Reidy provide an overview of the four issues identified within the proposed System Board Rules. THE MOTION CARRIED UNANIMOUSLY.

Ms. Reidy addressed the first issue, under Rule 2(e), which concerned the office of Board Secretary. She explained that Director Carvalho suggested that the Board elect a Board Secretary from among the Directors, but the Rules should include the addition of the Office of Deputy Secretary. The Deputy Secretary would not be a Director and would carry out the duties and responsibilities assigned by the Secretary. She noted that this change would be in lieu of suggestions to eliminate the Office of Secretary.

Director Greenspan, seconded by Director Ansell, moved to amend the Proposed Rules, to adopt the recommendation made by Director Carvalho, under which the Rules shall state that the Board elects a Board Secretary from among the Directors, and shall include the Office of Deputy Secretary. THE MOTION CARRIED UNANIMOUSLY.

Ms. Reidy addressed the second issue, under Rule 4(b), which concerned the determination of the number of members for each Standing Committee. She stated that Director Carvalho suggested that rather than set a fixed number of members for each committee, the number of members of each Standing Committee should be determined by the Chairperson but in no event shall such a committee consist of less than three (3) Director members. Ms. Reidy noted that if this suggestion is adopted, the remainder of the rules would be edited accordingly.

Director Ansell, seconded by Director Zopp, moved to amend the Proposed Rules, to adopt the recommendation made by Director Carvalho, under which the Rules shall state that the number of members of each Standing Committee shall be determined by the Chairperson but in no event shall such a committee consist of less than three (3) Director members. THE MOTION CARRIED UNANIMOUSLY.

Ms. Reidy addressed the third issue, under Rule 4(b)(2)(B), which concerned Director O'Donnell's suggestion that the Audit and Compliance Committee be folded into the Finance Committee or that it become a subcommittee of the Finance Committee. Ms. Reidy requested further direction from the Board on the issue.

Director O'Donnell explained the reason for the suggestion, however, she added that she would not have a problem if there were separate Finance and Audit Committees.

Chairman Batts asked Director Muñoz, Chairman of the Audit Committee, for his thoughts on the issue.

OLD BUSINESS (Continued)

Director Muñoz replied that enough issues came up in the Audit Committee's recent inaugural meeting to validate its separate existence. He felt that there were many important issues that needed deep attention, and that type of attention could be given by a separate Audit Committee.

Director Greenspan, seconded by Director Butler, moved to amend the Proposed Rules, to make the Audit Committee and Finance Committee separate committees. THE MOTION CARRED UNANIMOUSLY.

Ms. Reidy addressed the fourth issue, concerning Director Carvalho's suggestion to add language pertaining to conflict of interests on page 14 of the Proposed Rules. She noted that the Directors may want to consider providing that the provisions in the recommended language also apply to non-Director members of committees and subcommittees.

Director Greenspan, seconded by Director Butler, moved to amend the Proposed Rules, to include the following language in Rule 6, Conflicts of Interest:

(2) Any Director or non-Director member of a committee or subcommittee who has a conflict of interest in a matter involving the System shall declare the conflict to the System Board, or a committee or subcommittee, in open session, shall disclose the basis for the conflict and shall refrain from participating in the consideration of the matter, except as the Director may be called upon for information.

On the motion to amend, a voice vote was taken and THE MOTION CARRIED UNANIMOUSLY.

Ms. Reidy stated that the four issues identified by the State's Attorney have been addressed. She pointed out that all other changes already included in the Draft Rules before them would be accepted and adopted upon the approval of the Rules as amended. She offered the opportunity for Directors to address any other issues prior to the motion to approve and adopt the Rules, as amended.

Director Ansell inquired into the reason for Director Carvalho's suggestion on page 6 which allows for the exclusion of a Director who is not a member of a committee or subcommittee from attending a closed session of the committee or subcommittee.

Director Carvalho explained that the reason for this suggestion related to potential conflict of interest issues. He added that the language providing for this mechanism was not mandatory, but rather, permissive.

Director Muñoz stated that if a Director took the time to come to a meeting, they should be afforded the courtesy of attending the closed session. He felt that the Directors were competent enough to handle the situation if an issue arises, and did not believe the suggestion should be adopted.

Director Muñoz, seconded by Director Butler, moved to not include the language suggested by Director Carvalho on Page 6 of the Draft Rules, with regard to excluding Directors from attending the closed session of committees or subcommittees of which they are not a member. THE MOTION CARRIED UNANIMOUSLY.

OLD BUSINESS (Continued)

Director Ansell stated his preference that the name of the proposed Performance Improvement and Patient Safety Committee be changed to "Quality and Patient Safety Committee". Furthermore, he requested that in addition to the Chief Medical Officers and Presidents of the medical staffs of each institution who were proposed to be ex-officio members without a vote, the chief nursing officers and Chief Operating Officers of each institution should also be included as ex-officio members without a vote.

Director Zopp, seconded by Director Greenspan, moved to amend the Proposed Rules, and to adopt the recommendations made by Director Ansell to change the name of the proposed Performance Improvement and Patient Safety Committee to the Quality and Patient Safety Committee, and to include the chief nursing officers and Chief Operating Officers of each institution as ex-officio members of the Committee without a vote. THE MOTION CARRIED UNANIMOUSLY.

Director Zopp inquired into a notation made by the Office of the State's Attorney on page 14 of the Draft Rules with regard to recordings of meetings.

Ms. Reidy stated that the Board and its committees are subject to the Open Meetings Act, which requires the recording of closed sessions. The closed session recordings are protected by law, and are privileged. These recordings would not be disclosed willingly; a court would have to order the disclosure.

Director Zopp asked Ms. Reidy for direction on the inclusion of language with regard to audio recording and confidentiality, while complying with Freedom of Information Act and Open Meetings Act requirements.

Director Zopp, seconded by Director Butler, moved to amend the Proposed Rules, to require the recording of all meetings, including committee and subcommittee meetings, and to include language in the Rules with regard to audio recordings and confidentiality of closed session recordings, while complying with Freedom of Information Act and Open Meetings Act requirements.

Director Carvalho requested clarification on the motion made by Director Zopp with regard to public access of open session audio recordings.

Director Zopp stated that her intention was not to place any restrictions on public access to the recordings of open sessions.

On the motion to amend, a voice vote was taken and THE MOTION CARRIED UNANIMOUSLY.

Director Butler, seconded by Director Ramirez, moved to adopt the Rules of Organization and Procedure of the Board of Directors of the Cook County Health and Hospitals System Draft Version 2, dated July 23, 2008, to accept the marked revisions suggested by various Directors and to include the specific revisions voted upon at this meeting. THE MOTION CARRIED UNANIMOUSLY.

Chairman Batts stated that the Board will receive final copies of the Rules reflecting all revisions. (See Attachment #5.)

OLD BUSINESS (Continued)

ELECTION OF VICE CHAIRPERSON

Chairman Batts opened the floor to nominations for Vice Chairperson of the Board of Directors of the Cook County Health and Hospitals System.

Director Muñoz, seconded by Director Greenspan, moved to nominate Director Ramirez.

Director Carvalho, seconded by Director Lyne, moved to nominate Director Zopp.

Director Zopp, seconded by Director Carvalho, moved to nominate Director Ansell.

Director Zopp withdrew her own name from consideration upon the nomination of Director Ansell.

Upon hearing no other nominations, Chairman Batts closed the floor to nominations.

Director O'Donnell requested that the two candidates for Vice Chairman make a statement before the Board.

Directors Ramirez and Ansell presented brief statements to the Board with regard to their interest in the office of Vice Chairperson.

Voting proceeded for the election of Vice Chairperson of the Cook County Health and Hospitals System Board of Directors. A roll call was taken, the results are as follows:

ROLL CALL TO ELECT A VICE CHAIRPERSON OF THE COOK COUNTY HEALTH AND HOSPITALS SYSTEM BOARD OF DIRECTORS

In favor of Director Ansell for the position of Vice Chairperson:
Directors Carvalho, Lyne, O'Donnell and Zopp (4)

In favor of Director Ramirez for the position of Vice Chairperson:
Directors Butler, Golden, Greenspan, Muñoz and Ramirez (5)

Voting Present on the question:
Chairman Batts and Director Ansell (2)

With five votes in his favor, Director Ramirez was elected Vice Chairman of the Cook County Health and Hospitals System Board of Directors.

Director Muñoz, seconded by Director Zopp, moved to take a five minute recess. THE MOTION CARRIED UNANIMOUSLY.

After the five minute recess, Chairman Batts called the meeting back to order.

NEW BUSINESS

Committee Reports

Audit Committee.....Meeting of July 17, 2008

Director Muñoz, seconded by Director O'Donnell, moved to approve the Report of the Audit Committee for the meeting of July 17, 2008.

Director Carvalho pointed out that on page 5 of the Report of the Audit Committee, a reference to "Central Management Services" should instead be "Centers for Medicare and Medicaid Services".

On the motion to approve as amended, a voice vote was taken and THE MOTION CARRIED UNANIMOUSLY.

Committee Reports

Finance Committee.....Meeting of July 18, 2008

Director Greenspan requested that any submissions of materials to committees that are accepted by such committees be included with the report as an attachment for their review so that the information is shared with all Directors.

Director Carvalho, seconded by Director Ramirez, moved to approve the Report of the Finance Committee for the meeting of July 18, 2008. THE MOTION CARRIED UNANIMOUSLY.

Committee Reports

Human Resources Committee.....Meeting of July 21, 2008

Director Zopp, seconded by Director Lyne, moved to approve the Report of the Human Resources Committee for the meeting of July 21, 2008. THE MOTION CARRIED UNANIMOUSLY.

Committee Reports

Quality and Compliance Committee.....Meeting of July 21, 2008

Director Ansell, seconded by Director Butler, moved to approve the Report of the Quality and Compliance Committee for the meeting of July 21, 2008.

NEW BUSINESS (Continued)

Director Greenspan noted that on page 4 of the report, there were explicit listings of medical staff leadership appointment recommendations, and in accepting the Report of the Quality and Compliance Committee, the Board will be accepting the appointments.

Chairman Batts stated that it was duly noted.

On the motion to approve, a voice vote was taken and THE MOTION CARRIED UNANIMOUSLY.

DISCUSSION OF STRATEGIC PLANNING GUIDANCE FOR MANAGEMENT

Director Greenspan distributed a draft document to Chairman Batts and the Directors on the subject of the Strategic Planning Process. He indicated that discussion on the subject was expected to take place at a later date.

STATUS OF BARGAINING UNIT CONTRACTS AND CURRENT NEGOTIATIONS

Chairman Batts stated that this item was withdrawn, as the status of bargaining unit contracts and current negotiations was addressed at the meeting of the Human Resources Committee on July 21, 2008.

RECRUITMENT OF CHIEF EXECUTIVE OFFICER – INTERIM AND PERMANENT

DISCUSSION OF THE REPORT BY THE UNITED STATES DEPARTMENT OF JUSTICE, CIVIL RIGHTS DIVISION ISSUED JULY 11, 2008

Director Butler, seconded by Director Lyne, moved to recess the regular session and convene into closed session, pursuant to an exception to the Illinois Open Meetings Act, 5 ILCS 120/2(c)(1), et seq., which permits closed meetings for consideration of "The appointment, employment, compensation, discipline, performance, or dismissal of specific employees of the public body or legal counsel for the public body, including hearing testimony on a complaint lodged against an employee of the public body or against legal counsel for the public body to determine its validity," and pursuant to an exception to the Open Meetings Act, 5 ILCS 120/2(c)(11), which states: "Litigation, when an action against, affecting or on behalf of the particular body has been filed and is pending before a court or administrative tribunal, or when the public body finds that an action is probable or imminent, in which case the basis for the finding shall be recorded and entered into the minutes of the closed meeting". THE MOTION CARRIED UNANIMOUSLY.

Director Butler, seconded by Director Lyne, moved to adjourn the closed session and convene into regular session. THE MOTION CARRIED UNANIMOUSLY.

NEW BUSINESS (Continued)

Director Ansell, seconded by Director Lyne, moved that the Board create the position of interim Chief Medical Officer of the Bureau of Health Services, and to authorize Chairman Batts and the ad hoc Search Committee to identify such a candidate for the position through their search processes. THE MOTION CARRIED.

Director Carvalho voted No.

A consensus was reached to set the meeting dates for the rest of 2008 as soon as possible. Chairman Batts requested that the Secretary compile possible dates for the Board's review and subsequent approval at the Board's next meeting.

PUBLIC COMMENTS

Chairman Batts asked the Secretary to call upon the registered speakers.

1. George Blakemore	Concerned Citizen
2. Sherry E. Weingart, MPH	Concerned Citizen (written statement provided – Attachment #6)
3. Robyn Gabel	Executive Director, Illinois Maternal and Child Health Coalition (written statement provided – Attachment #7)

ADJOURNMENT

Director Lyne, seconded by Director Muñoz, moved to adjourn. THE MOTION CARRIED UNANIMOUSLY AND THE MEETING ADJOURNED.

Respectfully submitted,
Board of Directors of the
Cook County Health and Hospitals System

Warren L. Batts, Chairman

Attest:

Matthew B. DeLeon, Secretary

ATTACHMENT #1

July 22, 2008

MEMO TO: David Small
COO Bureau of Health

FROM: Cecil Marchand
Associate Administrator

Please find documentation you requested regarding the request to hire forms that were submitted to our department as follows:

REQUEST TO HIRE

POSTED POSITIONS:

STROGER 897	PROVIDENT 891	OAK FOREST 898	ACHN 893	BHS 890	CERMAK 240	PUBLIC HEALTH 895	CORE 894
190	32	36	27	20	24	47	3

379 (1)

PENDING INTERVIEWS:

STROGER 897	PROVIDENT 891	OAK FOREST 898	ACHN 893	BHS 890	CERMAK 240	PUBLIC HEALTH 895	CORE 894
6		2	2				

10 (2)

POSITIONS WAITING TO BE POSTED:

STROGER 897	PROVIDENT 891	OAK FOREST 898	ACHN 893	BHS 890	CERMAK 240	PUBLIC HEALTH 895	CORE 894
56	36	2	62		10		

(3)

166

545

(143)

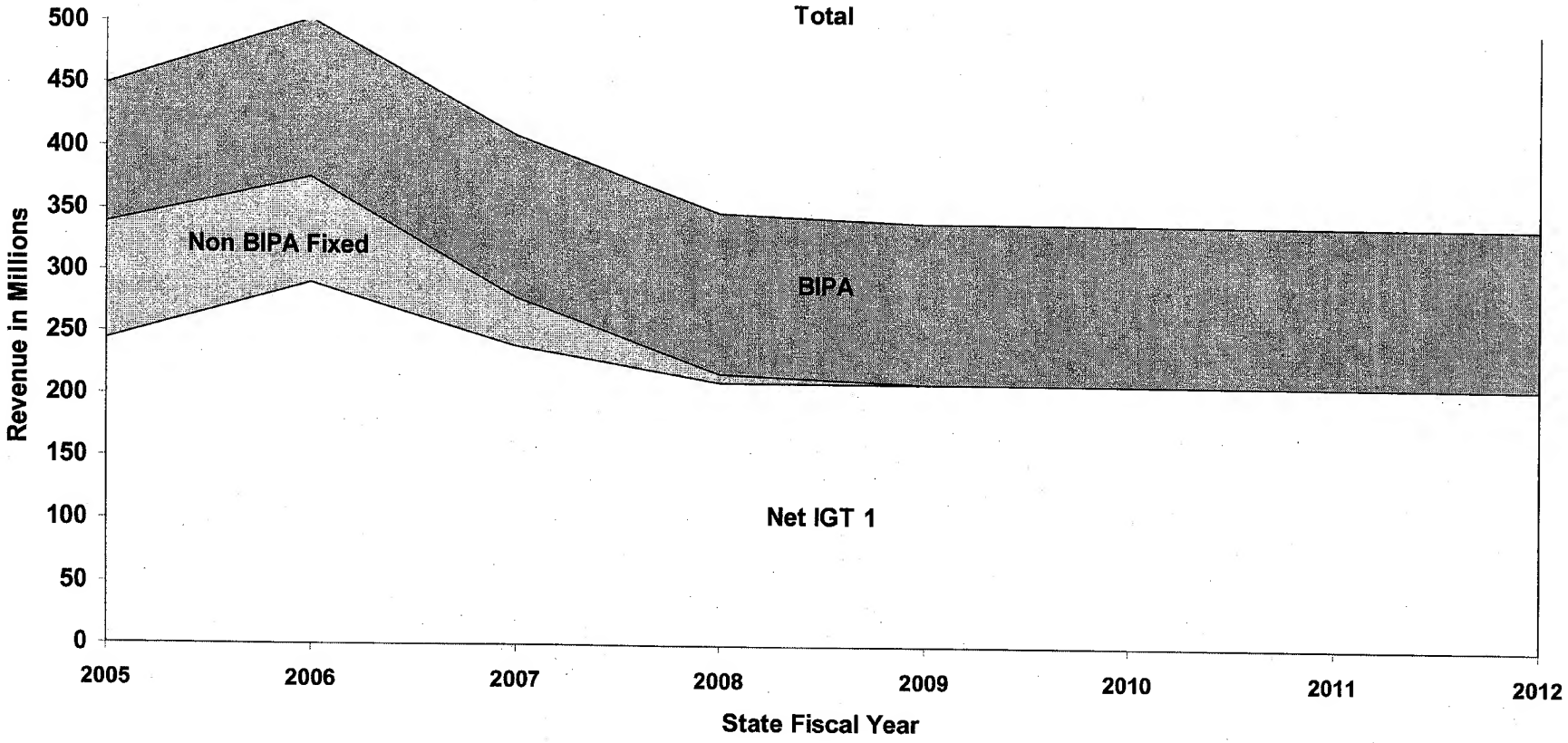
2008 Federal/State Financial Pressures and Opportunities for Cook County Health and Hospitals System

ATTACHMENT #2

Current Federal/State Financing Issues

- Fixed payments driven by provisions related to BIPA agreement caused a nearly $80 million loss in the past 3-4 years.
- Brief reprieve but continued pressure from federal cost-based rule and federal pressure on re-framing the upper limit calculations drive the current challenges
- Relationship with the state Medicaid has strengthened /improved. GRF and/or GRF related revenues have historically and at present remain a major challenge.
- Greater competition for Medicaid inpatients and outpatients due to the hospital assessment program and Primary Care Case Management (PCCM) "medical home" model for ambulatory care;

CCBHS Total Net State Revenues SFY '05- '12



NOTE – does not include 2008 DSH SPA

CCBHS Total Net State Revenues SFY '02- '10

	2002	2003	2004	2005	2006	2007	2008	2009	2010
Net IGT 1	252.37	235.28	299.42	244.45	290.73	240.11	211.60	211.60	211.60
Non BIPA Fixed	102.00	114.80	109.70	94.50	85.06	39.88	7.30	0	0
BIPA	0	37.21	88.53	110.20	127.30	131.25	131.25	131.25	131.25
Total	354.37	387.29	497.65	449.15	503.09	411.24	350.15	342.85	342.85

* Note: 2009 and 2010 projected steady with 2008; does not include 2008 DSH SPA

What is Pending in Baltimore

- A combined state plan amendment (submitted April 2008) that sets forth the assessment and a complementary state plan amendment that provides disproportionate share funding for Cook County hospital.
- As negotiations have continued, the state has agreed to separate the DSH SPA if the DSH SPA continues to generate relatively few questions from HHS. This separation may happen very soon.
- If DSH SPA Approved as is:
  - Funding scheduled to be $86.5 million for next year
  - More traditional way to access funds –federal and state "friendly"
  - Possibility for some retroactive funding
- Fight for predictability/PPS and fight for Cook's allocation i.e. other hospitals desire for DSH

What Didn't/Did pass Illinois General Assembly?

- **Did Not Pass**
- No GRF or GRF-like assistance

- Regional Tax – federal CMS and state reluctance to move quickly on unprecedented

- **Did Pass**
- Assessment bill that affects over 200 providers statewide
- Specific references to the County's part of the deal which:
  - Establishes a legislative intent that the state/GA/County will "discuss how mutual funding goals are to be achieved" if certain contingencies occur
  - Requires that CCBHS receive a fixed and sizeable portion of the DSH cap due to their high level of uncompensated care
  - Requires that the state submit the DSH SPA

Takeaways

- State and County will work for an increased DSH allocation that has a stronger relationship with its high level of uncompensated care

- Building a Stronger Financial Infrastructure:
  - Improve management of Medicaid and uncompensated care business, e.g.,
    - Remittance advice pilot and stronger revenue tracking mechanisms;
    - Improved and more timely cost reporting;
    - Enhanced revenue and cost reporting will enable higher quality strategic decision-making re Medicaid and uncompensated care sustainable business models;

Cook County Bureau of Health Services

Todd H. Stroger
President
Cook County Board of Commissioners

Robert R. Simon, M.D.
Interim Chief
Bureau of Health Services

David R. Small, FACHE
Chief Operating Officer
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1900 West Polk Street, Suite 123
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Affiliates:
Ambulatory & Community Health Network
Cermak Health Services
Cook County Department of Public Health
John H. Stroger, Jr. Hospital of Cook County
(formerly Cook County Hospital)
Oak Forest Hospital
Provident Hospital
Ruth M. Rothstein CORE Center

ATTACHMENT #3

July 17, 2008

Herb Kuhn
Deputy Administrator
Center for Medicare and Medicaid Services
7500 Security Blvd.
C5-25-25
Baltimore, MD 21244

Dear Mr. Kuhn:

The Cook County Bureau of Health Services is, by far, the largest safety net provider in the Chicago metropolitan area, and in the State of Illinois. Cook County hospitals and clinics provide the greatest volume of care for uninsured and for Medicaid patients of any provider in the state. Hundreds of millions of dollars in charity care is furnished every year. The County has longstanding, important relationships with the State and the federal government that recognize the unique contributions of Cook County to the regional and statewide healthcare infrastructure.

Over recent years, the Cook County Bureau of Health Services has lost access to tens of millions of dollars of Medicaid reimbursements due to implementation of federal regulations governing permissible payments to public hospitals. The strains to the financial foundations of the Bureau of Health caused by those losses regrettably contributed to reductions in our scope of health care services and healthcare access last year. Additional regulations yet scheduled for implementation through CMS may reduce further the potential Medicaid reimbursements to Cook County's safety net system providers.

In April of 2008, the State of Illinois submitted a State Plan Amendment (transmittal number 08-06) that, among other things, would permit Disproportionate Share Hospital (DSH) payments to be made to County hospitals. Cook County is very excited about this opportunity that would enable continuation of services to tens of thousands of uninsured clients. We believe that this proposed amendment to Illinois' DSH program is fully consistent with principles articulated by the Administration and by CMS for financing healthcare for the uninsured through public providers, and that CMS will be supportive of the proposal once it is fully reviewed.

The Illinois General Assembly passed Senate Bill 2857 this spring to support that State Plan Amendment. The County worked very closely with the State of Illinois to craft that legislation and to submit the State Plan Amendment.

We respectfully request that you consider expedited approval of the Illinois' State Plan Amendment 08-06 with respect to the DSH proposal. This funding stream is critical to the County's present and future. Timing is extremely important to the County as we approach the final quarter of our County fiscal year, and key decisions soon must be made that may materially impact patient access across our system.

We understand that the proposed DSH 'SPA' was "bundled" with the State of Illinois' proposed program alterations for an extended, or modified statewide Hospital Assessment Tax. Cook County has encouraged the State to work with CMS to split the proposed State Plan Amendment into separate components.. As we understand it, the DSH section of the State's request has generated very few questions to this point, perhaps because of its routine character and its comportment with CMS objectives. While the provider assessment portion of the State plan amendment may well ultimately be approved, you uniquely would know that this may require more lengthy discussions and negotiations that could delay review and approval of the DSH request..

I believe at the present moment that the future looks bright for our public hospital and health system in Cook County. A new independent governance authority recently has been convened that will provide new direction for the system from an expert panel with a wide variety of professional experience. This new governance effort, combined with the stabilization of revenues, will contribute significantly to a public health care system of high integrity and high quality.

We look forward to working with you, and with the State in reaching our shared goals of providing access and quality care to our patients.

Sincerely your,

David R. Small
Chief Operating Officer

DRS/rlm

Cc: Todd H. Stroger, President, Cook County Board of Commissioners
Warren Batts, Chairman, Board of Directors, Cook County Health and Hospitals System
Barry Maram, Director, Illinois Dept. of Healthcare and Family Services

RULES OF ORGANIZATION AND PROCEDURE
Of the Board of Directors of the
Cook County Health and Hospitals System

Preamble

The Cook County Board of Commissioners established the Cook County Health and Hospitals System ("CCHHS") by Ordinance. The CCHHS is governed by a Board of Directors ("System Board") as set forth in the Ordinance. The Ordinance sets forth the mission of the CCHHS and the general powers and duties of the System Board. In order to provide for the orderly implementation of the Ordinance, the System Board adopts these Rules.

Rule 1. Purpose.

The purpose of these Rules is to:

(a) Provide appropriate procedures and organization for the System Board to conduct its business in an orderly and efficient manner; and

(b) Foster accountability in the CCHHS.

Rule 2. Definitions.

The following words, terms and phrases, when used in these Rules, shall have the meanings ascribed to them in this section, except where the context clearly indicates a different meaning:

(a) *Chairperson* means the Chairperson of the System Board. (*Director Carvalho prefers the term Chair rather than Chairperson.)

(b) Committee *Chairperson* means the chairperson of a standing or special committee or a subcommittee thereof. (*Director Carvalho prefers the term Chair rather than Chairperson.)

(c) *Committee* means a committee of the System Board and includes a standing committee, a special committee and a standing or special subcommittee of a committee.

(d) *Director* means a currently serving member of the System Board.

(e) *Secretary* means the Secretary of the System Board. (*Director O'Donnell suggests that the position of Secretary be eliminated and that the System Board or the Chairperson be

authorized to hire someone to fulfill this role as needed. If this suggestion is adopted, any references to the role of Secretary in these Rules will be edited accordingly.)

(f) *System Board* means the eleven-member Board of Directors charged with governing the CCHHS.

(g) *Vice Chairperson* means the Vice Chairperson of the System Board.

Rule 3. Interpretation, force and effect.

(a) *Applicability.* The meetings and actions of the System Board, including all of its committees, shall be governed by these Rules.

(b) *Effective date.* These Rules shall be in full force and effect upon adoption by the System Board, and shall remain in full force and effect except as amended in accordance herewith, or until superseded by new rules.

(c) *Interpretation.* These Rules are to be construed in accordance with the customary American usage and meaning of parliamentary terms and expressions and the plain meaning of the ordinary words appearing herein. In case of ambiguous application, these Rules shall be applied in a manner that fosters openness, accountability and fairness in the operation of the System Board.

Rule 4. Organization.

(a) *Officers.* The System Board, each year at its annual meeting, shall elect Directors to serve as Chairperson, Vice-Chairperson, and Secretary. (*This section will be edited accordingly if the office of Secretary is eliminated.) A Director may be elected to any of the officer positions for successive terms.

(1) Chairperson.

The Chairperson shall preside at all meetings of the System Board, shall appoint from among the System Board members, all the members of all standing and special committees and their subcommittees, and designate their Committee Chairperson, shall be an ex-officio member, with vote, of all committees of the System Board. The Chairperson may, at the Chairperson's discretion unless otherwise instructed by the System Board, refer matters before the System Board to the proper committee of said System Board for consideration and recommendation. The Chairperson or the Chairperson's designee shall be responsible for all correspondence of the System Board.

(2) Vice Chairperson

The Vice-Chairperson shall perform the duties of the Chairperson in the Chairperson's absence or in the event of the Chairperson's resignation, death, or disability pending selection of the Chairperson's successor at either a regular or special meeting of the System Board.

(3) Secretary

The Secretary shall keep suitable records of all proceedings of each meeting of the System Board and its committees and subcommittees. After approval, such records shall be read and signed by the Chairperson or the presiding officer, and attested by the Secretary. The System Board may have a seal on which shall be engraved the name of the CCHHS, and said seal shall be kept by the Secretary and used in authentication of all acts of the System Board. (*This section will be edited accordingly if the office of Secretary is eliminated.)

(*Director Carvalho suggests adding the following office:

"(4) Deputy Secretary

The Deputy Secretary shall not be a Director and shall carry out those duties and responsibilities assigned by the Secretary." SAO Note: This change would be in lieu of the change to eliminate the office of Secretary.)

(b) *Standing committees and subcommittees.*

(*Director Carvalho suggests the following:

"(1) The number of members of each Standing Committees shall be determined by the Chairperson but in no event shall such a committee consist of less than three (3) Director members." SAO Note: If this proposed is adopted, the remainder of the Rules will be edited accordingly.)

(2) The standing committees of the System Board shall be:

(A) Finance: five (5) Directors, including the Committee Chairperson, but not including the Chairperson. This Committee shall be familiar with and review the income and expenditures of the CCHHS, advise the Chief Executive Officer, Chief Operating Officer and Chief Financial Officer in preparation of the budget, review the proposed budget in advance of presentation to the System Board, and make recommendations to the System Board on all such financial matters. Additionally, this Committee will develop and present to the System Board, a recommended multi-year financing plan in support of the

CCHHS strategic plan adopted by the System Board. This Committee shall be responsible for developing, implementing and monitoring policies and procedures regarding procurement and contracting for the CCHHS, including providing for appropriate review of purchase contracts by this Committee. This Committee shall further develop its responsibilities and determine a plan to implement those responsibilities. This Committee shall consider other matters as may be assigned by the System Board. (*Committee membership is changed from four to five to reflect actual committee assignments. Addition regarding procurement and contracting suggested by Director O'Donnell.)

(B) Audit and Compliance: three (3) Directors, including the Committee Chairperson, but not including the Chairperson. This Committee shall receive and review the audit reports prepared by internal departments and oversees the financial reporting process on behalf of the CCHHS. This Committee shall oversee the selection of independent auditors for the CCHHS in accordance with the enabling ordinance, review accounting policies and financial reporting and disclosure practices of the CCHHS, and review the effectiveness of the CCHHS internal financial controls. Additionally, the Committee will assist the System Board in fulfilling its oversight responsibilities of the CCHHS corporate compliance effort. This Committee shall further develop its responsibilities and determine a plan to implement those responsibilities. This Committee shall consider other matters as may be assigned by the System Board. (*Director O'Donnell suggests that the Audit and Compliance Committee be folded into the Finance Committee or that it become a subcommittee of the Finance Committee.)(C) Performance Improvement and Patient Safety: four (4) Directors, including the Committee Chairperson, but not including the Chairperson. The President of each CCHHS medical staff shall be an ex-officio member of this Committee without a vote and shall not be considered for determining a quorum. The Chief Medical Officer of each operating unit of the CCHHS shall be an ex-officio member of this Committee without a vote and shall not be considered for determining a quorum. This Committee shall oversee the quality, safety and performance improvement programs of the CCHHS, with the goal of recognizing the critical importance of maintaining high quality service and patient and staff safety and satisfaction. This Committee shall receive reports on pertinent matters of quality, safety, satisfaction, regulatory and accreditation activities at least quarterly from the CCHHS Chief Executive Officer's office, and shall report on such matters to the System Board. This Committee shall be responsible for serving as a liaison between the CCHHS' hospital medical staffs and the System Board. It shall also be responsible for overseeing the appointments and reappointments to the hospital medical staffs. An additional purpose of this Committee is the full and candid discussion of matters which affect the CCHHS' medical staffs and the System Board. This Committee shall further develop its

responsibilities and determine a plan to implement those responsibilities. This Committee shall consider other matters as may be assigned by the System Board. (*Changes suggested by Chairperson Batts and Director O'Donnell, reflecting recommended change to incorporate the functions of the Medical Affairs Committee and to eliminate that Committee. See immediately below.)

(*Change suggested by Chairperson Batts and Director O"Donnell. See above, (C), Performance and Improvement of Patient Safety, where the liaison and appointment/reappointment functions have been relocated.)

(D) Human Resources: five (5) Directors, including the Committee Chairperson, but not including the Chairperson. This Committee shall develop and monitor policies and procedures for the CCHHS related to personnel issues with regard to all employees, including physicians and dentists, within the CCHHS, including, but not limited to, position classification, compensation, recruitment, selection, hiring, discipline, termination, grievance, affirmative action, performance management, probationary periods, training, promotion and maintenance of records. This Committee shall further develop its responsibilities and determine a plan to implement those responsibilities. This Committee shall also consider other matters as assigned by the System Board. (*Committee membership is changed from four to five to reflect actual committee assignments. Addition adding "monitor" suggested by State's Attorney's Office.)

(3) A standing committee may create a subcommittee. The motion creating a subcommittee shall specify the subject matter of the subcommittee and the number of members to be appointed thereto, and may specify a date upon which the subcommittee shall be abolished.

(3) Following each meeting of a standing committee, the Committee Chairperson shall submit a report to the System Board for consideration at a meeting of the System Board. The System Board shall either approve or receive and file a committee report. Approval of a committee's report by the System Board shall constitute approval of the actions and/or recommendations contained in the report. (*Addition suggested by the State's Attorney's Office.)

(c) *Membership and officers of standing committees and subcommittees.*

(1) The members of each standing committee shall be appointed annually by the Chairperson. The Chairperson may appoint non-Director members to a standing committee. The Committee Chairperson shall appoint the members of a subcommittee and the Subcommittee Chairperson. The Committee Chairperson may appoint non-Director members to a subcommittee. The non-Director member of a standing committee

or a subcommittee shall not have a vote, shall not be considered for a quorum but may serve as Committee or Subcommittee Chairperson.

(2) The Chairperson shall be an ex-officio member, with voting rights, of each standing committee to which the Chairperson is not an appointed member.

(3) A vacancy on a standing committee or subcommittee, or in the position of Committee Chairperson or Subcommittee Chairperson, shall be created when a Director resigns from such position or ceases to be a Director. Resignations shall be made in writing to the Secretary, who shall promptly notify the Chairperson and all Directors. (*This section will be edited accordingly if the office of Secretary is eliminated.)

(4) Vacancies on standing committees or in the position of Committee Chairperson shall be filled by appointment by the Chairperson. Vacancies on subcommittees or in the position of Subcommittee Chairperson shall be filled by the Committee Chairperson of the committee which created the subcommittee.

(5) The Committee Chairperson or Subcommittee Chairperson shall have the authority to call and preside at meetings of their respective committee or subcommittee.

(6) An y Director, even if not a member of a committee or subcommittee, s hall be afforded the courtesy of participating in debate on any item before a committee or subcommittee. (*Director Carvalho suggests considering adding the following: "Notwithstanding the foregoing, a Director who is not a member of a committee or a subcommittee is excluded from attending a closed session of such committee or subcommittee.")

(7) At the end of each fiscal year, each Committee Chairperson shall report a summary of all matters pending in her or his committee to the System Board.

(d) *Special committees and subcommittees.*

(1) The System Board may create special committees. The Chairperson shall appoint the Committee Chairperson and the members of a special committee. The Chairperson may appoint non-Director members to a special committee or subcommittee. The non-Director member shall not have a vote, shall not be considered for a quorum but may serve as Committee Chairperson.

(2) The Chairperson shall be an ex-officio member, with voting rights, of each special committee.

(3) A special committee may create a special subcommittee.

(4) The motion creating a special committee or special subcommittee shall specify the subject matter of the special committee or special subcommittee and the number of members to be appointed thereto, and may specify a reporting date in which event the special committee or special subcommittee shall be abolished as of such date. Unless an earlier date is specified by the motion, special committees and special subcommittees shall expire one (1) year after their creation.

(e) *Public hearings.* The System Board may hold public hearings as it deems appropriate to the performance of any of its responsibilities. Such public hearings may be held provided that the following requirements are satisfied:

(1) a notice containing the time, place, subject matter of the hearing, and solicitation of pertinent public testimony shall be (*Director Carvalho suggests deleting the following: and editing the following: placed on the CCHHS' website and provided to the County for posting on its website.)

(2) an y other applicable meeting notification requirements found elsewhere in these Rules or law.

(f) *Discharge from a committee by the System Board.* The System Board may discharge any matter from a committee.

Rule 5. Parliamentary rules.

(a) *Meetings.*

(1) The System Board shall hold regular meetings pursuant to an annual calendar set by the System Board prior to December 1st of each year. Such calendar shall include the date, time, and location of each regular meeting. The last regular meeting of System Board shall be held in November and shall be the Annual Meeting. Election of System Board officers for the next year shall take place at the Annual Meeting. (*Change suggested by State's Attorney's Office.)

(2) It shall be the duty of the Chairperson to call special meetings of the System Board whenever the Chairperson determines such meetings are necessary. In addition to any notice required by the Open Meetings Act or other applicable law, the Chairperson must give no less than two business days advance written notice of such special meetings to the Directors.

(3) Special meetings shall also be held whenever requested by at least one-third of the Directors. In addition to any notice required by the Open Meetings Act or other applicable law, the Secretary or his or her designee must give no less than two business days advance written notice of such special meetings to the remaining Directors. (*This section will be edited accordingly if the office of Secretary is eliminated.)

(4) A special meeting may be called in the event that the Chairperson or one-third of the System Board states that an emergency exists. The Secretary or his or her designee must give no less than twenty-four (24) hours advance written notice to the Directors and to the public, unless such notice is not reasonable under the circumstances. In such case notice shall be given as soon as practicable. (*This section will be edited accordingly if the office of Secretary is eliminated.)

(5) All notices of special meetings must include an agenda for such meeting.

(6) A quorum of Directors must be physically present at the location of a meeting of the System Board, its committees or subcommittees.

(A) If a quorum of the Directors is physically present at a meeting of the System Board or one of its committees or subcommittees, a majority of the Directors present and entitled to vote may allow a Director to attend the meeting by other means if the Director is prevented from physically attending because of: (i) personal illness or disability; (ii) employment purposes or the business of the public body; or (iii) a family or other emergency. "Other means" is by video or audio conference. (*Change suggested by State's Attorney's Office.)

(B) If a Director wishes to attend a meeting by other means, the Director must notify the Secretary before the meeting unless advance notice is impractical. (*This section will be edited accordingly if the office of Secretary is eliminated.)

(b) *Presiding officer.* The Chairperson shall preside at all meetings of the System Board and shall generally perform the duties customarily performed by a presiding officer. In the absence of the Chairperson, or during the temporary inability of the Chairperson to act, the Vice-Chairperson shall preside at meetings of the System Board. If both the Chairperson and the Vice Chairperson

are unable to preside at the meeting, the System Board shall appoint a Director to preside at that meeting. In the absence of a Committee Chairperson, or during the temporary inability of the Committee Chairperson to act, the Directors of that Committee shall appoint a Director who is a member of that committee to preside at that meeting.

(c) *Quorum.* A majority of the Directors shall constitute a quorum for a meeting of the System Board. A majority of Directors appointed to any committee or subcommittee shall constitute a quorum for a meeting of such committee or subcommittee.

(d) *Majority votes.* Actions of the System Board shall require the affirmative vote of a majority of the Directors present and voting at the meeting at which action is taken. Actions of a committee or subcommittee of the System Board shall require the affirmative vote of a majority of the Directors present and entitled to vote at the meeting at which action is taken. A vote of "present" shall not be counted in determining the number of Directors voting on a question.

(e) *Absence of quorum.* Should a quorum not be present at any meeting of the System Board or at any committee or subcommittee meeting, the meeting shall not thereby stand adjourned, but the Directors present shall be competent to adjourn, receive information or public testimony but take no formal action, or recess the meeting to a specified date and time by a majority vote of those Directors present and entitled to vote.

(f) *Order of business.*

(1) At each regular meeting of the System Board, the order of business (unless otherwise directed by the System Board) is as follows:

(A) Call to Order and Roll Call.
(B) Approval and correction of minutes of previous meetings.
(C) Report of the Chief Executive Officer
(D) Committee reports.
(E) Old business.
(F) New business.
(G) Adjournment.

(2) The System Board may grant members of the public leave to speak for up to three (3) minutes on items pending before the System Board.

(3) All questions relating to the priority of business shall be decided by the presiding officer, without debate, subject to appeal.

(g) *Prior notice to public; agendas.*

(1) No less than two full business days before any meeting of the System Board or of a committee or subcommittee, notice and an agenda for such meeting shall be provided to the Chairperson, all Directors and all news media that have requested notice of meetings and shall be posted at the principal office of the System Board and at the location where the meeting is to be held. In addition, notices and agendas of all meetings shall be posted on the CCHHS website, if available, (*Director Carvalho suggests the following change: and provided to the County for posting on its website.)

(2) The agenda shall briefly describe all matters that will be considered at the meeting. Material pertinent to a matter on a System Board agenda shall be supplied, along with the agenda, to the Chairperson and to each of the Directors, and all material pertinent to any matter on a committee or subcommittee agenda shall be supplied, along with the agenda, to each member of the committee or subcommittee. With the exception of materials that are confidential as provided by law, such material shall also be available to the public upon request.

(3) Matters may be placed on the agenda of a System Board meeting by the Chairperson or any Director. Committee reports shall be placed on the agenda of a System Board meeting by the Committee Chair. Matters may be placed on the agenda of a committee or subcommittee meeting by a Director who is a member of the committee or the Chairperson, in his ex officio capacity.

(4) Matters may be placed on an agenda not later than noon of the day previous to the day on which that agenda is required to be distributed or at the discretion of the Chairperson.

(5) It shall be the duty of the Secretary or his or her designee to prepare, post, and distribute all agendas for meetings of the System Board, and it shall be the duty of the Secretary or his or her designee to prepare, post, and distribute agendas for committee and subcommittee meetings. (*This section will be edited accordingly if the office of Secretary is eliminated.)

(h) *Decorum.* The presiding officer shall preserve order and decorum, may speak to points of order in preference to other Directors, and shall decide all questions of order, subject to appeal. A Director shall confine herself or himself to the matters before the System Board, avoid personalities, and in general observe all parliamentary rules pertaining to orderly procedure and decorum.

(i) *Recognition for debate.* A Director desiring to obtain the floor shall address the presiding officer. If two or more Directors shall properly request recognition, the presiding officer shall recognize the one who first spoke. A Director shall not proceed with remarks until recognized and named by the presiding officer. The Chairperson and all Directors shall be given a full opportunity to participate in the debate on all debatable questions, except when a Director has called the previous question.

(j) *Debate.* No Director shall speak more than twice or longer than a total of ten minutes on the same question, without leave of the System Board. Responses by witnesses and CCHHS staff to questions of a Director shall not be counted against the speaking time allotted to such Director. The proponent of the item under consideration, or a Committee Chairperson whose report is under consideration, as the case may be, shall have the right to open and close debate.

(k) *Voting and roll call*

(1) If any Director requests it, a roll call upon any question shall be taken and entered in the minutes, but a roll call shall not be taken unless called for prior to, during or immediately after any vote on the question.

(2) A roll call once ordered shall not be interrupted. When a roll call has commenced, all debate on the question shall be deemed concluded. During the taking of the roll call, Directors shall respond to the calling of their names by answering "yea," "nay," or "present."

(l) *Division of questions.* If any question presented contains several separable propositions, a demand by any Director to "divide the question" shall be in order.

(m) *Appeal from a ruling of the presiding officer.* Any Director entitled to vote may appeal to the System Board, committee or subcommittee from a ruling of the presiding officer. The Director making the appeal may briefly state the reason for the appeal, and the presiding officer may briefly explain the ruling; but there shall be no debate on the appeal and no other Director shall participate in the discussion. The presiding officer shall then put the question, "Shall the decision of the Chairperson [Committee Chairperson] be sustained?" If a majority of Directors vote "nay," the decision of the presiding officer shall be overruled; otherwise, it shall be sustained. If sustained, the ruling of the presiding officer shall be final.

(n) *Personal privilege.* The right of a Director to address the System Board, a committee or subcommittee on a question of personal privilege shall be limited to cases in which the Director's integrity, character, or motives are assailed, questioned, or impugned.

(o) *Special order of business.* Any matter before the System Board, a committee, or subcommittee referenced in an agenda provided to the Directors and the public in accordance with these rules may be taken out of order by the presiding officer.

(p) *Order of precedence during debate.* When a question is under debate, the following motions shall be in order and shall have precedence over each other in order, as listed:

(1) To adjourn to a day certain (amendable, debatable).
(2) To adjourn.
(3) To take a recess (debatable).
(4) To lay on the table.
(5) To call the previous question.
(6) To refer (debatable).
(7) To amend (amendable, debatable).
(8) To defer to a time certain (debatable).
(9) To defer indefinitely (amendable, debatable).

(q) *Motion to adjourn.* A motion to adjourn is always in order except:

(1) When a Director has the floor.
(2) When the roll is being called or the Directors are voting.
(3) When the previous motion was a motion to adjourn.
(4) When the "previous question" has been ordered.

(r) *Motion to reconsider.*

(1) A vote or question may be reconsidered at any time during the same meeting, at a special meeting called to reconsider the vote or question held prior to the next regular meeting or at the next regular meeting.

(2) A motion for reconsideration, having been once made and decided in the negative, shall not be renewed, nor shall a motion to reconsider be reconsidered.

(3) A motion to reconsider must be made by a Director who voted on the prevailing side of the question to be reconsidered.

(s) *Amendment or suspension of rules.*

(1) Any provision of these Rules may be temporarily suspended by a majority vote of the Directors present and entitled to vote at a System Board meeting or meeting of a committee or subcommittee, upon motion of any Director specifying the rule to be suspended.(*Change suggested by the State's Attorney's Office.)

(2) The provisions of these Rules may not be altered or amended in whole or in part except by motion adopted by a majority vote of the Directors.

(t) *Rules for committee meetings.* Unless otherwise specified in these Rules, the rules of procedure for all committee, subcommittee and special committee meetings shall be the same as for System Board meetings.

(u) *Robert's Rules of Order.* The rules of parliamentary practice set forth in "Robert's Rules of Order" (Newly Revised, 10th Edition) by Henry M. Robert III, *et al.*, shall govern the System Board in all cases in which they are applicable and not inconsistent with the provisions of these Rules.

(v) *Recordings of meetings.* The Secretary or his or her designee is responsible for audio recording all meetings of the System Board. The audio recordings of public meetings of the System Board shall be retained by the Secretary or his or her designee. (*Director Carvalho suggests adding the following: Audio recordings of closed sessions shall be retained by the Secretary or his or her designee in a secure fashion and shall not be available to any person, including any Director, except upon motion of the System Board or as required by law.) (*This section will be edited accordingly if the office of Secretary is eliminated.)

Rule 6. Conflict of Interest.

(1) While serving on the System Board, Directors shall act in the best interest of the CCHHS in all matters relating to the CCHHS. The provisions of the Cook County Ethics Ordinance shall apply to the Directors. Each Director shall annually complete a Disclosure of Interest Statement on a form adopted by the System Board which form shall be filed with the Secretary. (*This section will be edited accordingly if the office of Secretary is eliminated.) The Directors may adopt a Professional and Ethical Protocol consistent with the Ethics Ordinance.

(*Director Carvalho suggests the following:)

(2) Any Director who has a conflict of interest in a matter involving the System shall declare the conflict to the System Board, or a committee or subcommittee, in open session, shall disclose the basis for the conflict and shall refrain from participating in the consideration of the matter, except as the Director may be called upon for information.

Note: SAO Note: Consider providing that the provisions in section (2) also apply to non-Director members of committees or subcommittees.

Rule 7. Official Position Statements

Official position statements of the System Board will be made only after concurrence of a majority of the Directors and shall be issued only through the Chairperson or the Chairperson's designee.

*State's Attorney's Office Miscellaneous Notes:

The Open Meetings Act provides that a verbatim record must be kept of all closed portions of meetings in the form of an audio or video recording. In addition, the Office of the Secretary, which is currently preparing the minutes for all System Board meetings, prefers that all open sessions also be audio recorded in order to prepare accurate minutes. Do you wish to include a provision in the System Board Rules stating that all Committee and Subcommittee meetings shall be audio recorded?

RULES OF ORGANIZATION AND PROCEDURE
Of the Board of Directors of the
Cook County Health and Hospitals System

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Preamble

The Cook County Board of Commissioners established the Cook County Health and Hospitals System ("CCHHS") by Ordinance. The CCHHS is governed by a Board of Directors ("System Board") as set forth in the Ordinance. The Ordinance sets forth the mission of the CCHHS and the general powers and duties of the System Board. In order to provide for the orderly implementation of the Ordinance, the System Board adopts these Rules.

Rule 1. Purpose.

The purpose of these Rules is to:

(a) Provide appropriate procedures and organization for the System Board to conduct its business in an orderly and efficient manner; and

(b) Foster accountability in the CCHHS.

Rule 2. Definitions.

The following words, terms and phrases, when used in these Rules, shall have the meanings ascribed to them in this section, except where the context clearly indicates a different meaning:

(a) Chair means the Chair of the System Board.

(b) *Committee Chair* means the chair of a standing or special committee or a subcommittee thereof.

(c) *Committee* means a committee of the System Board and includes a standing committee, a special committee and a standing or special subcommittee of a committee.

(d) *Director* means a currently serving member of the System Board.

(e) *Secretary* means the Secretary of the System Board.

(f) *System Board* means the eleven-member Board of Directors charged with governing the CCHHS.

(g) *Vice Chair* means the Vice Chair of the System Board.

Rule 3. Interpretation, force and effect.

(a) *Applicability*. The meetings and actions of the System Board, including all of its committees, shall be governed by these Rules.

(b) *Effective date.* These Rules shall be in full force and effect upon adoption by the System Board, and shall remain in full force and effect except as amended in accordance herewith, or until superseded by new rules.

(c) *Interpretation.* These Rules are to be construed in accordance with the customary American usage and meaning of parliamentary terms and expressions and the plain meaning of the ordinary words appearing herein. In case of ambiguous application, these Rules shall be applied in a manner that fosters openness, accountability and fairness in the operation of the System Board.

Rule 4. Organization.

(a) *Officers.* The System Board, each year at its annual meeting, shall elect Directors to serve as Chair, Vice-Chair, and Secretary. A Director may be elected to any of the officer positions for successive terms.

(1) Chair.

The Chair shall preside at all meetings of the System Board, shall appoint from among the System Board members all the members of all standing and special committees and their subcommittees, and designate their Committee Chair, shall be an ex-officio member, with vote, of all committees of the System Board. The Chair may, at the Chair's discretion unless otherwise instructed by the System Board, refer matters before the System Board to the proper committee of said System Board for consideration and recommendation. The Chair or the Chair's designee shall be responsible for all correspondence of the System Board.

(2) Vice Chair.

The Vice-Chair shall perform the duties of the Chair in the Chair's absence or in the event of the Chair's resignation, death, or disability pending selection of the Chair's successor at either a regular or special meeting of the System Board.
(3) Secretary.

The Secretary shall keep suitable records of all proceedings of each meeting of the System Board and its committees and subcommittees. After approval, such records shall be read and signed by the Chair or the presiding officer, and attested by the Secretary. The System Board may have a seal on which shall be engraved the name of the CCHHS, and said seal shall be kept by the Secretary and used in authentication of all acts of the System Board.

(4) Deputy Secretary.

The Deputy Secretary shall be appointed by the System Board, shall not be a Director and shall carry out those duties and responsibilities assigned by the Secretary.

(b) *Standing committees and subcommittees.*
(1) The number of members of each Standing Committee shall be determined by the Chair but in no event shall a Standing Committee consist of less than three (3) Director members.

(2) The standing committees of the System Board shall be:

A. Finance. This Committee shall be familiar with and review the income and expenditures of the CCHHS, advise the Chief Executive Officer, Chief Operating Officer and Chief Financial Officer in preparation of the budget, review the proposed budget in advance of presentation to the System Board, and make recommendations to the System Board on all such financial matters. Additionally, this Committee will develop and present to the System Board, a recommended multi-year financing plan in support of the CCHHS strategic plan adopted by the System Board. This Committee shall be responsible for developing, implementing and monitoring policies and procedures regarding procurement and contracting for the CCHHS, including providing for appropriate review of purchase contracts by this Committee. This Committee shall further develop its responsibilities and determine a plan to implement those responsibilities. This Committee shall consider other matters as may be assigned by the System Board.

B. Audit and Compliance. This Committee shall receive and review the audit reports prepared by internal departments and oversee the financial reporting process on behalf of the CCHHS. This Committee shall oversee the selection of independent auditors for the CCHHS in accordance with the enabling ordinance, review accounting policies and financial reporting and disclosure practices of the CCHHS, and review the effectiveness of the CCHHS internal financial controls. Additionally, the Committee will assist the System Board in fulfilling its oversight responsibilities of the CCHHS corporate compliance effort. This Committee shall further develop its responsibilities and determine a plan to implement those responsibilities. This Committee shall consider other matters as may be assigned by the System Board.

C. Quality and Patient Safety. The President of each CCHHS medical staff shall be an ex-officio member of this Committee without a vote and shall not be considered for determining a quorum. The Chief Medical Officer, Chief Operating Officer, and Chief Nursing Officer of each operating unit of the CCHHS shall be an ex-officio member of this Committee without a vote and shall not be considered for determining a quorum. This Committee shall oversee the quality, safety and performance improvement programs of the CCHHS, with the goal of recognizing the critical importance of maintaining high quality service and patient and staff safety and satisfaction. This Committee shall receive reports on pertinent matters of quality, safety, satisfaction, regulatory and accreditation activities at least quarterly from the CCHHS Chief Executive Officer, and shall report on such matters to the System Board. This Committee shall be responsible for serving as a liaison between the CCHHS' hospital medical staffs and the System Board. It shall also be responsible for overseeing the appointments and reappointments to the hospital medical staffs. An additional purpose of this Committee is the full and candid discussion of matters which affect the CCHHS'

medical staffs and the System Board. This Committee shall further develop its responsibilities and determine a plan to implement those responsibilities. This Committee shall consider other matters as may be assigned by the System Board.

D. Human Resources: This Committee shall develop and monitor policies and procedures for the CCHHS related to personnel issues with regard to all employees, including physicians and dentists, within the CCHHS, including, but not limited to, position classification, compensation, recruitment, selection, hiring, discipline, termination, grievance, affirmative action, performance management, probationary periods, training, promotion and maintenance of records. This Committee shall further develop its responsibilities and determine a plan to implement those responsibilities.

(3) A standing committee may create a subcommittee. The motion creating a subcommittee shall specify the subject matter of the subcommittee and the number of members to be appointed thereto, and may specify a date upon which the subcommittee shall be abolished.

(4) Following each meeting of a standing committee, the Committee Chair shall submit a report to the System Board for consideration at a meeting of the System Board. The System Board shall either approve or receive and file a committee report. Approval of a committee's report by the System Board shall constitute approval of the actions and/or recommendations contained in the report.

(c) *Membership and officers of standing committees and subcommittees.*

(1) The members of each standing committee shall be appointed annually by the Chair. The Chair may appoint non-Director members to a standing committee. The Committee Chair shall appoint the members of a subcommittee and the Subcommittee Chair. The Committee Chair may appoint non-Director members to a subcommittee. The non-Director member of a standing committee or a subcommittee shall not have a vote and shall not be considered for a quorum, but may serve as Committee or Subcommittee Chair.

(2) The Chair shall be an ex-officio member, with voting rights, of each standing committee to which the Chair is not an appointed member.

(3) A vacancy on a standing committee or subcommittee, or in the position of Committee Chair or Subcommittee Chair, shall be created when a Director resigns from such position or ceases to be a Director. Resignations shall be made in writing to the Secretary, who shall promptly notify the Chair and all Directors.

(4) Vacancies on standing committees or in the position of Committee Chair shall be filled by appointment by the Chair. Vacancies on subcommittees or in the position of Subcommittee Chair shall be filled by the Committee Chair of the committee which created the subcommittee.

(5) The Committee Chair or Subcommittee Chair shall have the authority to call and preside at meetings of their respective committee or subcommittee.

(6) Any Director, even if not a member of a committee or subcommittee, shall be afforded the courtesy of participating in debate on any item before a committee or subcommittee.

7) At the end of each fiscal year, each Committee Chair shall report a summary of all matters pending in her or his committee to the System Board.

(d) *Special committees and subcommittees.*

(1) The System Board may create special committees. The Chair shall appoint the Committee Chair and the members of a special committee. The Chair may appoint non-Director members to a special committee or subcommittee. The non-Director member shall not have a vote and shall not be considered for a quorum, but may serve as Committee Chair.

(2) The Chair shall be an ex-officio member, with voting rights, of each special committee.

(3) A special committee may create a special subcommittee.

(4) The motion creating a special committee or special subcommittee shall specify the subject matter of the special committee or special subcommittee and the number of members to be appointed thereto, and may specify a reporting date in which event the special committee or special subcommittee shall be abolished as of such date. Unless an earlier date is specified by the motion, special committees and special subcommittees shall expire one (1) year after their creation.

(e) *Public hearings.* The System Board may hold public hearings as it deems appropriate to the performance of any of its responsibilities. Such public hearings may be held provided that the following requirements are satisfied:

(1) a notice containing the time, place, subject matter of the hearing, and solicitation of pertinent public testimony shall be placed on the CCHHS' website and provided to the County for posting on its website.
(2) any other applicable meeting notification requirements found elsewhere in these Rules or law.

(f) *Discharge from a committee by the System Board.* The System Board may discharge any matter from a committee.

Rule 5. Parliamentary rules.

(a) *Meetings.*

The System Board shall hold regular meetings pursuant to an annual calendar set by the System Board prior to December 1st of each year. Such calendar shall include the date, time, and location of each regular meeting. The last regular meeting of System Board

shall be held in November and shall be the Annual Meeting. Election of System Board officers for the next year shall take place at the Annual Meeting.

It shall be the duty of the Chair to call special meetings of the System Board whenever the Chair determines such meetings are necessary. In addition to any notice required by the Open Meetings Act or other applicable law, the Chair must give no less than two business days advance written notice of such special meetings to the Directors.

Special meetings shall also be held whenever requested by at least one-third of the Directors. In addition to any notice required by the Open Meetings Act or other applicable law, the Secretary or his or her designee must give no less than two business days advance written notice of such special meetings to the remaining Directors.

A special meeting may be called in the event that the Chair or one-third of the System Board states that an emergency exists. The Secretary or his or her designee must give no less than twenty-four (24) hours advance written notice to the Directors and to the public, unless such notice is not reasonable under the circumstances. In such case notice shall be given as soon as practicable.

(5) All notices of special meetings must include an agenda for such meeting.

(6) A quorum of Directors must be physically present at the location of a meeting of the System Board, its committees or subcommittees.

If a quorum of the Directors is physically present at a meeting of the System Board or one of its committees or subcommittees, a majority of the Directors present and entitled to vote may allow a Director to attend the meeting by other means if the Director is prevented from physically attending because of: (i) personal illness or disability; (ii) employment purposes or the business of the public body; or (iii) a family or other emergency. "Other means" is by video or audio conference.

If a Director wishes to attend a meeting by other means, the Director must notify the Secretary before the meeting unless advance notice is impractical.

(b) *Presiding officer*. The Chair shall preside at all meetings of the System Board and shall generally perform the duties customarily performed by a presiding officer. In the absence of the Chair, or during the temporary inability of the Chair to act, the Vice-Chair shall preside at meetings of the System Board. If both the Chair and the Vice Chair are unable to preside at the meeting, the System Board shall appoint a Director to preside at that meeting. In the absence of a Committee Chair, or during the temporary inability of the Committee Chair to act, the Directors of that Committee shall appoint a Director who is a member of that committee to preside at that meeting.

(c) *Quorum*. A majority of the Directors shall constitute a quorum for a meeting of the System Board. A majority of Directors appointed to any committee or subcommittee shall constitute a quorum for a meeting of such committee or subcommittee.

(d) *Majority votes.* Actions of the System Board shall require the affirmative vote of a majority of the Directors present and voting at the meeting at which action is taken. Actions of a committee or subcommittee of the System Board shall require the affirmative vote of a majority of the Directors present and entitled to vote at the meeting at which action is taken. A vote of "present" shall not be counted in determining the number of Directors voting on a question.

(e) *Absence of quorum.* Should a quorum not be present at any meeting of the System Board or at any committee or subcommittee meeting, the meeting shall not thereby stand adjourned, but the Directors present shall be competent to adjourn, receive information or public testimony but take no formal action, or recess the meeting to a specified date and time by a majority vote of those Directors present and entitled to vote.

(f) *Order of business.*

(1) At each regular meeting of the System Board, the order of business (unless otherwise directed by the System Board) is as follows:

(A) Call to Order and Roll Call.
(B) Approval and correction of minutes of previous meetings.
(C) Report of the Chief Executive Officer
(D) Committee reports.
(E) Old business.
(F) New business.
(G) Adjournment.

(2) The System Board may grant members of the public leave to speak for up to three (3) minutes on items pending before the System Board.

(3) All questions relating to the priority of business shall be decided by the presiding officer, without debate, subject to appeal.

(g) *Prior notice to public; agendas.*

(1) No less than two full business days before any meeting of the System Board or of a committee or subcommittee, notice and an agenda for such meeting shall be provided to the Chair, all Directors and all news media that have requested notice of meetings and shall be posted at the principal office of the System Board and at the location where the meeting is to be held. In addition, notices and agendas of all meetings shall be posted on the CCHHS website, if available, and provided to the County for posting on its website.

(2) The agenda shall briefly describe all matters that will be considered at the meeting. Material pertinent to a matter on a System Board agenda shall be supplied, along with the agenda, to the Chair and to each of the Directors, and all material pertinent to any matter on a committee or subcommittee agenda shall be supplied, along with the agenda, to each member of the committee

or subcommittee. With the exception of materials that are confidential as provided by law, such material shall also be available to the public upon request.

(3) Matters may be placed on the agenda of a System Board meeting by the Chair or any Director. Committee reports shall be placed on the agenda of a System Board meeting by the Committee Chair. Matters may be placed on the agenda of a committee or subcommittee meeting by a Director who is a member of the committee or the Chair, in his ex officio capacity.

(4) Matters may be placed on an agenda not later than noon of the day previous to the day on which that agenda is required to be distributed or at the discretion of the Chair.

> It shall be the duty of the Secretary or his or her designee to prepare, post, and distribute all agendas for meetings of the System Board, and for committee and subcommittee meetings.

(h) *Decorum.* The presiding officer shall preserve order and decorum, may speak to points of order in preference to other Directors, and shall decide all questions of order, subject to appeal. A Director shall confine herself or himself to the matters before the System Board, avoid personalities, and in general observe all parliamentary rules pertaining to orderly procedure and decorum.

(i) *Recognition for debate.* A Director desiring to obtain the floor shall address the presiding officer. If two or more Directors shall properly request recognition, the presiding officer shall recognize the one who first spoke. A Director shall not proceed with remarks until recognized and named by the presiding officer. The Chair and all Directors shall be given a full opportunity to participate in the debate on all debatable questions, except when a Director has called the previous question.

(j) *Debate.* No Director shall speak more than twice or longer than a total of ten minutes on the same question, without leave of the System Board. Responses by witnesses and CCHHS staff to questions of a Director shall not be counted against the speaking time allotted to such Director. The proponent of the item under consideration, or a Committee Chair whose report is under consideration, as the case may be, shall have the right to open and close debate.

(k) *Voting and roll call*

(1) If any Director requests it, a roll call upon any question shall be taken and entered in the minutes, but a roll call shall not be taken unless called for prior to, during or immediately after any vote on the question.

(2) A roll call once ordered shall not be interrupted. When a roll call has commenced, all debate on the question shall be deemed concluded. During the taking of the roll call, Directors shall respond to the calling of their names by answering "yea," "nay," or "present."

(l) *Division of questions.* If any question presented contains several separable propositions, a demand by any Director to "divide the question" shall be in order.

(m) *Order of precedence during debate*. When a question is under debate, the following motions shall be in order and shall have precedence over each other in order, as listed:

(n) *Appeal from a ruling of the presiding officer*. Any Director entitled to vote may appeal to the System Board, committee or subcommittee from a ruling of the presiding officer. The Director making the appeal may briefly state the reason for the appeal, and the presiding officer may briefly explain the ruling; but there shall be no debate on the appeal and no other Director shall participate in the discussion. The presiding officer shall then put the question, "Shall the decision of the Chair [Committee Chair] be sustained?" If a majority of Directors vote "nay," the decision of the presiding officer shall be overruled; otherwise, it shall be sustained. If sustained, the ruling of the presiding officer shall be final.

(o) *Personal privilege*. The right of a Director to address the System Board, a committee or subcommittee on a question of personal privilege shall be limited to cases in which the Director's integrity, character, or motives are assailed, questioned, or impugned.

(p) *Special order of business*. Any matter before the System Board, a committee, or subcommittee referenced in an agenda provided to the Directors and the public in accordance with these rules may be taken out of order by the presiding officer.

(q) *Order of precedence during debate*. When a question is under debate, the following motions shall be in order and shall have precedence over each other in order, as listed:

(1) To adjourn to a day certain (amendable, debatable).
(2) To adjourn.
(3) To take a recess (debatable).
(4) To lay on the table.
(5) To call the previous question.
(6) To refer (debatable).
(7) To amend (amendable, debatable).
(8) To defer to a time certain (debatable).
(9) To defer indefinitely (amendable, debatable).

(r) *Motion to adjourn*. A motion to adjourn is always in order except:

(1) When a Director has the floor.
(2) When the roll is being called or the Directors are voting.
(3) When the previous motion was a motion to adjourn.
(4) When the "previous question" has been ordered.

(s) *Motion to reconsider*.

A vote or question may be reconsidered at any time during the same meeting, at a special meeting called to reconsider the vote or question held prior to the next regular meeting or at the next regular meeting.

(2) A motion for reconsideration, having been once made and decided in the negative, shall not be renewed, nor shall a motion to reconsider be reconsidered.

A motion to reconsider must be made by a Director who voted on the prevailing side of the question to be reconsidered.

(t) *Amendment or suspension of rules.*

(1) Any provision of these Rules may be temporarily suspended by a majority vote of the Directors present and entitled to vote at a System Board meeting or meeting of a committee or subcommittee, upon motion of any Director specifying the rule to be suspended.

The provisions of these Rules may not be altered or amended in whole or in part except by motion adopted by a majority vote of the Directors.

(u) *Rules for committee meetings.* Unless otherwise specified in these Rules, the rules of procedure for all committee, subcommittee and special committee meetings shall be the same as for System Board meetings.

(v) *Robert's Rules of Order.* The rules of parliamentary practice set forth in "Robert's Rules of Order" (Newly Revised, 10th Edition) by Henry M. Robert III, *et al.*, shall govern the System Board in all cases in which they are applicable and not inconsistent with the provisions of these Rules.

(w) *Recordings of meetings.* The Secretary or his or her designee is responsible for audio recording all meetings of the System Board. The audio recordings of public meetings of the System Board shall be retained by the Secretary or his or her designee. Audio recordings of meetings other than closed sessions shall be available for review upon written request to the Secretary or his or her designee. Audio recordings of closed sessions shall be retained by the Secretary or his or her designee in a secure fashion and shall not be available to any person except as required by law.

Rule 6. Conflict of Interest.

While serving on the System board, Directors shall act in the best interest of the CCHHS in all matters relating to the CCHHS. The provisions of the Cook County Ethics Ordinance shall apply to the Directors. Each Director shall annually complete a Disclosure of Interest Statement on a form adopted by the System board which form shall be filed with the Secretary. The Directors may adopt a Professional and Ethical Protocol consistent with the Ethics ordinance.

Any Director or non-Director member of a committee or subcommittee who has a conflict of interest in a matter involving the System shall declare the conflict to the System Board, or a committee or subcommittee, in open session, shall disclose the basis

for the conflict and shall refrain from participating in the consideration of the matter, except as the Director may be called upon for information.

Rule 7. Official Position Statements

Official position statements of the System Board will be made only after concurrence of a majority of the Directors and shall be issued only through the Chair or the Chair's designee.

Testimony Prepared for the
Board of Directors of the Cook County Health and Hospitals System

Concerning Major Changes in Cook County Department of Public Health Services Due to Transitioning Out of Direct Provision of Family Case Management

July 23, 2008

Prepared by Sherry E. Weingart, M.P.H.

Good morning, Directors and other distinguished attendees. While my remarks today concern the Cook County Department of Public Health's (CCDPH) decision to reduce direct Family Case Management (FCM) services, I am not addressing the advisability of that decision. Instead, I wish to concentrate on the implications of the process, going forward, for the Department and the people in its jurisdiction. I am testifying not as a formal representative of any of the public health associations and organizations to which I belong. Rather, I am here to offer the views of one public health practitioner, analyst and advocate of how CCDPH and this esteemed body may be able to anticipate and prevent some serious negative consequences, and even produce lemonade.

A few quick points:

1) *There is precedent for local health departments transitioning out of selected direct service provision in a way that strengthens the local health authority's ability to assure lasting quality and improved population-based health outcomes.* The present trajectory set in motion by CCDPH and IDHS augurs ill for this transition's success. What is on track to happen is that after CCDPH ends its involvement, the State will establish direct contracts with contractors, and the Department will be powerless to monitor and influence local implementation, not the least of which cause will be that they will no longer receive program and client data.

2) *How you frame the leadership challenge here is crucial to outcomes.* This appears to have been framed as "We tried to secure ongoing support, but we can no longer afford this. Other entities can pick this up. Our management challenge in this immediate crisis is:

a. provide for good clinical hand-off for enrolled clients
b. minimize labor objection by reassignment
c. continue some intensive service to approximately 20% of the highest risk communities
d. re-define our 'core business' as concentrating on the services we're paid for and those which cannot be done in the private sector
e. close ranks and take the heat because no one outside the County apparatus can understand the details of the dilemmas we face."

There is another way. It's cheaper than running the program, but is not free. The leadership, versus management, challenge should be framed as: "Let's use this opportunity to strengthen our position as the public health authority and to assure the best possible birth outcomes in the present and future, by:

a. increasing our systemic capacity for oversight, including addressing longstanding informatics issues with respect to service and patient-level outcome data, and with respect to real-time usable population-based data to guide program adjustments
b. providing dedicated epidemiologic surveillance specific to maternal and child health (MCH)
c. establishing contract terms with IDHS so that their subcontractors are subject to our quality review and outcome monitoring and linkage
d. assigning a small team of highly skilled Public Health Nurses (PHN) to offer 'anticipatory guidance' to the new service providers.
e. transitioning leadership and decision-making style from a preference for opacity to a dedication to transparency: regarding employees, potential service partners and the community as assets who must contribute to collaborative leadership."

3) *CCDPH cannot wait to conduct an elaborated strategic planning process with long horizons to set in place the structural relationships and contractual terms which will allow it to influence the outcome of the transition.* It must demand, and fund, the leadership role it must play.

Distributed: Supplementary materials from NACCHO, MCHB, oral testimony by S. Weingart, MPH

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MCHB = Maternal and Child Health Bureau of US DHHS Health Resources + Services Agency?

MCHB uses the construct of a pyramid to describe the four levels of core public health services for the MCH population. Starting at the base, these are (1) infrastructure-building services, (2) population-based services, (3) enabling services, and (4) direct health care (gap-filling) services. Infrastructure-building and population-based services provide the broad foundation upon which enabling and direct care services rest (Figure A-1). The MCH health services pyramid provides a useful framework for understanding programmatic directions and resource allocation by the Bureau and its partners as they collaborate to carry out the MCHB mission and accomplish the MCHB goals.

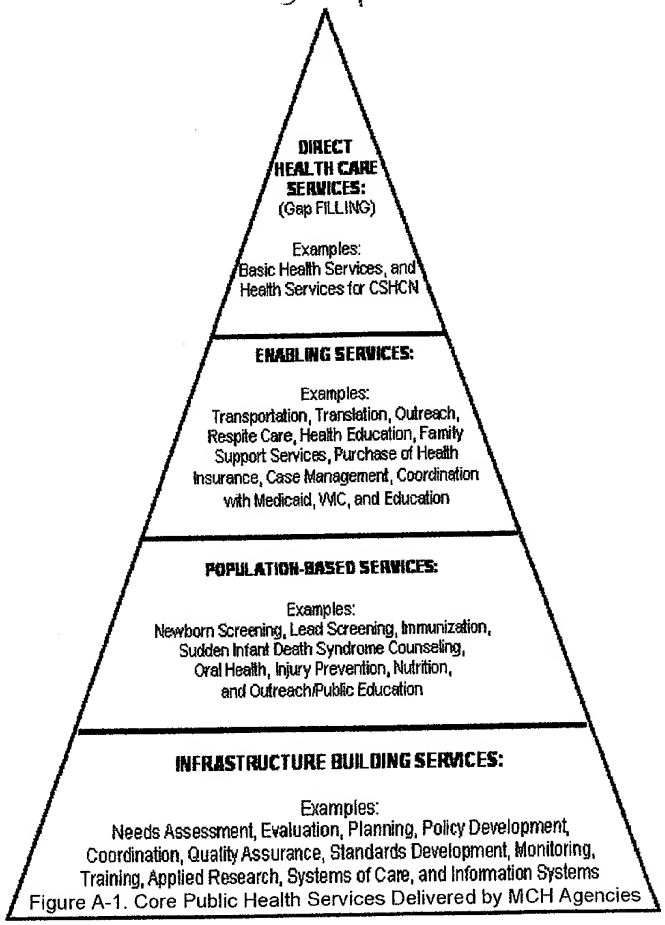

Figure A-1. Core Public Health Services Delivered by MCH Agencies

MCH leaders work at all four levels of the pyramid. Leaders emerge within each of these four levels and can move between levels as their careers progress.

(HRSA. MCH TRAINING GRANTEE NETWORK - 2007)
http://leadership.mchtrainings.net/index.php July 2008

NACCHO NATIONAL ASSOCIATION OF COUNTY & CITY HEALTH OFFICIALS

Operational Definition *of a* functional local health department

Governmental public health departments are responsible for creating and maintaining conditions that keep people healthy. At the local level, the governmental public health presence, or "local health department," can take many forms.[1] Furthermore, each community has a unique "public health system" comprising individuals and public and private entities that are engaged in activities that affect the public's health. Regardless of its governance or structure, regardless of where specific authorities are vested or where particular services are delivered, everyone, no matter where they live, should reasonably expect the local health department to meet certain standards.[2]

A FUNCTIONAL LOCAL HEALTH DEPARTMENT:

- Understands the specific health issues confronting the community, and how physical, behavioral, environmental, social, and economic conditions affect them.
- Investigates health problems and health threats.
- Prevents, minimizes, and contains adverse health effects from communicable diseases, disease outbreaks from unsafe food and water, chronic diseases, environmental hazards, injuries, and risky health behaviors.
- Leads planning and response activities for public health emergencies.
- Collaborates with other local responders and with state and federal agencies to intervene in other emergencies with public health significance (e.g., natural disasters).
- Implements health promotion programs.
- Engages the community to address public health issues.
- Develops partnerships with public and private healthcare providers and institutions, community-based organizations, and other government agencies (e.g., housing authority, criminal justice, education) engaged in services that affect health to collectively identify, alleviate, and act on the sources of public health problems.
- Coordinates the public health system's efforts in an intentional, non-competitive, and non-duplicative manner.
- Addresses health disparities.
- Serves as an essential resource for local governing bodies and policymakers on up-to-date public health laws and policies.
- Provides science-based, timely, and culturally competent health information and health alerts to the media and to the community.
- Provides its expertise to others who treat or address issues of public health significance.
- Ensures compliance with public health laws and ordinances, using enforcement authority when appropriate.
- Employs well-trained staff members who have the necessary resources to implement best practices and evidence-based programs and interventions.
- Facilitates research efforts, when approached by researchers, that benefit the community.
- Uses and contributes to the evidence base of public health.
- Strategically plans its services and activities, evaluates performance and outcomes, and makes adjustments as needed to continually improve its effectiveness, enhance the community's health status, and meet the community's expectations.

NOTES

[1] For the purposes of this definition, a local health department may be locally governed, part of a region or district, be an office or an administrative unit of the state health department, or a hybrid of these.

[2] See "Local Health Department Standards," Pages 4 through 9, for further description of the functions captured in this definition.

All local health departments (LHDs),[1] as governmental entities, derive their authority and responsibility from the state and local laws that govern them. Accordingly, all LHDs exist for the common good and are responsible for demonstrating strong leadership in the promotion of physical, behavioral, environmental, social, and economic conditions that improve health and well-being; prevent illness, disease, injury, and premature death; and eliminate health disparities.[2] However, in the absence of specific, consistent standards regarding how LHDs fulfill this responsibility, the degree to which the public's health is protected and improved varies widely from community to community.

These standards describe the responsibilities that every person, regardless of where they live, should reasonably expect their LHD to fulfill. They have been developed within nationally recognized frameworks[3] and with input from public health professionals and elected officials[4] from across the country. The standards provide a framework by which LHDs are accountable to the state health department, the public they serve, and the governing bodies (e.g., local boards of health, county commissioners, and mayors) to which they report. In meeting the standards, LHDs employ strategies that are evidence-based and informed by best practices, and they operate according to the highest level of professionalism and ethics to inspire public confidence and trust.

A number of factors contribute to the variability of how LHDs operate; specifically capacity, authority, resources, and composition of the local public health system:

- The LHD may have the capacity to perform all of the functions on its own; it may call upon the state to provide assistance for some functions; it may develop arrangements with other organizations in the community or with neighboring LHDs to perform some functions; or it may control the means by which other entities perform some functions.
- Government agencies other than the LHD may have the authority to perform services that affect public health.
- Resources for public health may be housed in a different agency.
- Each LHD jurisdiction is served by its own unique public health system: public and private health care providers, businesses, community organizations, academic institutions, and media outlets that all contribute to the public's health.

As a result of these differences, how LHDs meet the standards—whether they directly provide a service, broker particular capacities, or otherwise ensure that the necessary work is being done—will vary. Regardless of its specific capacity, authority, and resources, and regardless of the particular local public health system, the LHD has a consistent responsibility to intentionally coordinate all public health activities and lead efforts to meet the standards.

The standards are a guide to the fundamental responsibilities of LHDs, allowing for varied structural characteristics of LHDs (e.g., governance, staffing patterns, size of the population served, etc.), and recognizing that each LHD may have other duties unique to meeting the public health needs of the community it serves. Several states have developed, or are in the process of developing, state-specific standards for LHDs, and the National Public Health Performance Standards Program (NPHPSP) includes standards for local public health systems. NACCHO analyses of several state initiatives and the NPHPSP have shown a high level of consistency between these efforts and NACCHO's nationally developed standards.

Currently, not all LHDs have the capacity to meet the standards. Many concerns have been raised regarding the costs of developing the capacity, and the implications for LHDs that do not meet the standards. It is difficult to anticipate costs, and it is equally important to understand that improvements in capacity can be made in the absence of new resources. NACCHO is committed to collecting and sharing models of LHDs and LHD arrangements to demonstrate various means to enhance local governmental public health capacity. Furthermore, NACCHO is currently participating in a national dialogue on whether to establish a voluntary national accreditation system for state and local health departments,[5] and is supportive of such an effort.[6] The results of this dialogue may generate implications for LHDs not meeting the standards.

NACCHO urges LHDs to embrace these standards both as a means of working with their state health departments, communities, and governing bodies to develop a more robust governmental public health capacity, and as a means of holding themselves uniformly accountable to the public they serve.

1. Monitor health status and understand health issues facing the community.
    a. Obtain and maintain data that provide information on the community's health (e.g., provider immunization rates; hospital discharge data; environmental health hazard, risk, and exposure data; community-specific data; number of uninsured; and indicators of health disparities such as high levels of poverty, lack of affordable housing, limited or no access to transportation, etc.).
    b. Develop relationships with local providers and others in the community who have information on reportable diseases and other conditions of public health interest and facilitate information exchange.
    c. Conduct or contribute expertise to periodic community health assessments.
    d. Integrate data with health assessment and data collection efforts conducted by others in the public health system.
    e. Analyze data to identify trends, health problems, environmental health hazards, and social and economic conditions that adversely affect the public's health.

2. Protect people from health problems and health hazards.
    a. Investigate health problems and environmental health hazards.
    b. Prevent, minimize, and contain adverse health events and conditions resulting from communicable diseases; food-, water-, and vector-borne outbreaks; chronic diseases; environmental hazards; injuries; and health disparities.
    c. Coordinate with other governmental agencies that investigate and respond to health problems, health disparities, or environmental health hazards.
    d. Lead public health emergency planning, exercises, and response activities in the community in accordance with the National Incident Management System, and coordinate with other local, state, and federal agencies.
    e. Fully participate in planning, exercises, and response activities for other emergencies in the community that have public health implications, within the context of state and regional plans and in a manner consistent with the community's best public health interest.
    f. Maintain access to laboratory and biostatistical expertise and capacity to help monitor community health status and diagnose and investigate public health problems and hazards.
    g. Maintain policies and technology required for urgent communications and electronic data exchange.

3. Give people information they need to make healthy choices.
    a. Develop relationships with the media to convey information of public health significance, correct misinformation about public health issues, and serve as an essential resource.
    b. Exchange information and data with individuals, community groups, other agencies, and the general public about physical, behavioral, environmental, social, economic, and other issues affecting the public's health.
    c. Provide targeted, culturally appropriate information to help individuals understand what decisions they can make to be healthy.
    d. Provide health promotion programs to address identified health problems.

4. Engage the community to identify and solve health problems.
    a. Engage the local public health system in an ongoing, strategic, community-driven, comprehensive planning process to identify, prioritize, and solve public health problems; establish public health goals; and evaluate success in meeting the goals.
    b. Promote the community's understanding of, and advocacy for, policies and activities that will improve the public's health.
    c. Support, implement, and evaluate strategies that address public health goals in partnership with public and private organizations.
    d. Develop partnerships to generate interest in and support for improved community health status, including new and emerging public health issues.
    e. Inform the community, governing bodies, and elected officials about governmental public health services that are being provided, improvements being made in those services, and priority health issues not yet being adequately addressed.

5. Develop public health policies and plans.

a. Serve as a primary resource to governing bodies and policymakers to establish and maintain public health policies, practices, and capacity based on current science and best practices.
b. Advocate for policies that lessen health disparities and improve physical, behavioral, environmental, social, and economic conditions in the community that affect the public's health.
c. Engage in LHD strategic planning to develop a vision, mission, and guiding principles that reflect the community's public health needs, and to prioritize services and programs.

6. Enforce public health laws and regulations.

a. Review existing laws and regulations and work with governing bodies and policymakers to update them as needed.
b. Understand existing laws, ordinances, and regulations that protect the public's health.
c. Educate individuals and organizations on the meaning, purpose, and benefit of public health laws, regulations, and ordinances and how to comply.
d. Monitor, and analyze over time, the compliance of regulated organizations, entities, and individuals.
e. Conduct enforcement activities.
f. Coordinate notification of violations among other governmental agencies that enforce laws and regulations that protect the public's health.

7. Help people receive health services.

a. Engage the community to identify gaps in culturally competent, appropriate, and equitable personal health services, including preventive and health promotion services, and develop strategies to close the gaps.
b. Support and implement strategies to increase access to care and establish systems of personal health services, including preventive and health promotion services, in partnership with the community.
c. Link individuals to available, accessible personal healthcare providers (i.e., a medical home).

8. Maintain a competent public health workforce.

a. Recruit, train, develop, and retain a diverse staff.
b. Evaluate LHD staff members' public health competencies,[7] and address deficiencies through continuing education, training, and leadership development activities.
c. Provide practice- and competency based educational experiences for the future public health workforce, and provide expertise in developing and teaching public health curricula, through partnerships with academia.
d. Promote the use of effective public health practices among other practitioners and agencies engaged in public health interventions.
e. Provide the public health workforce with adequate resources to do their jobs.

9. Evaluate and improve programs and interventions.

a. Develop evaluation efforts to assess health outcomes to the extent possible.
b. Apply evidence-based criteria to evaluation activities where possible.
c. Evaluate the effectiveness and quality of all LHD programs and activities and use the information to improve LHD performance and community health outcomes.
d. Review the effectiveness of public health interventions provided by other practitioners and agencies for prevention, containment, and/or remediation of problems affecting the public's health, and provide expertise to those interventions that need improvement.

10. Contribute to and apply the evidence base of public health.

a. When researchers approach the LHD to engage in research activities that benefit the health of the community,
   i. Identify appropriate populations, geographic areas, and partners;
   ii. Work with them to actively involve the community in all phases of research;
   iii. Provide data and expertise to support research; and,
   iv. Facilitate their efforts to share research findings with the community, governing bodies, and policymakers.
b. Share results of research, program evaluations, and best practices with other public health practitioners and academics.
c. Apply evidence-based programs and best practices where possible.

NOTES

[1] For the purposes of these standards, an LHD is defined as the governmental public health presence at the local level. It may be a locally governed health department, a branch of the state health department, a state-created district or region, a department governed by and serving a multi-county area, or any other arrangement that has governmental authority and is responsible for public health functions at the local level.

[2] For the purposes of this document, "health disparities" refer to differences in populations' health status that are avoidable and can be changed. These differences can result from social and/or economic conditions, as well as public policy. Examples include situations whereby hazardous waste sites are located in poor communities, there is a lack of affordable housing, and there is limited or no access to transportation. These and other factors adversely affect population health.

[3] The standards are framed around the Ten Essential Public Health Services, which have been reworded to more accurately reflect the specific LHD roles and responsibilities related to each category. In addition, these standards are consistent with the National Public Health Performance Standards Program (NPHPSP), serving to specify the role of governmental LHDs while the NPHPSP addresses the public health system as a whole.

[4] This includes those from local health departments, local boards of health, state health departments, and federal public health agencies; as well as county commissioners, mayors, state legislators, and gubernatorial health advisors.

[5] www.exploringaccreditation.org

[6] NACCHO Resolution 04-06 further describes NACCHO's stance on accreditation.

[7] As defined by the Core Public Health Competencies developed by the Council on Linkages between Academia and Public Health Practice.

Public health professionals and the communities they serve deserve a common set of expectations about local health departments (LHDs). More than 600 governmental public health professionals and local and state officials representing 30 different states contributed to this definition, which will be a living document.

By describing the functions of LHDs, the definition will help citizens and residents understand what they can reasonably expect from governmental public health in their communities. The definition also will be useful to elected officials, who need to understand what LHDs do and how to hold them accountable. And, the definition will aid LHDs in obtaining their fair share of resources.

WHAT ARE NACCHO'S NEXT STEPS?

NACCHO's first step is education and communication about the definition with LHDs, local boards of health, state health departments, federal public health agenices, and local and state elected officials. Metrics will be developed to allow LHDs to measure their progress in achieving the standards. NACCHO will also gather examples of how LHDs use the definition. The Exploring Accreditation project will examine the use of the standards as the basis for a voluntary national accreditation system for LHDs of all sizes and structures.

WHAT ACTION STEPS CAN YOU TAKE?

LHDs can use the definition and standards to assess local efforts, measure performance, expand functions, enhance activities, and communicate about the role of local public health to their governing bodies, elected officials, and community.

NACCHO has developed a set of three fact sheets describing the role of local public health and a communications toolkit as part of this project. Both the toolkit and the fact sheets are available on NACCHO's Web site (see the following column). We encourage LHDs to download the fact sheets and communications toolkit.

Finally, your experiences with the definition will inform and help shape the implementation phase of this effort. Please submit examples of how LHDs have met the definition (particularly those involving the development of shared capacity and/or resources), applied the tools in the communications toolkit, or otherwise used the definition or related materials. You can find additional materials and submit examples online at: www.naccho.org/topics/infrastructure/operationaldefinition.cfm.

For more information about this project, please contact NACCHO at (202) 783-5550 and ask to speak with the Operational Definition program manager, or e-mail operationaldefinition@naccho.org.

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NACCHO

National Association of County & City Health Officials

No. 04-11

STATEMENT OF POLICY

LOCAL HEALTH DEPARTMENT EPIDEMIOLOGY AND SURVEILLANCE CAPACITIES

Policy

The National Association of County and City Health Officials (NACCHO) supports the development of local health department (LHD) epidemiology and surveillance capacities to promote evidence-based public health practice. Epidemiology and surveillance capacities include having, or having access to, sufficient personnel and systems to: 1) recognize promptly and respond effectively to disease outbreaks and other public health issues; 2) monitor and analyze the incidence and prevalence of diseases of public health significance; 3) provide LHDs, and others with a need to know, with accurate and timely data to ensure sufficient resource allocation to areas of greatest need; and 4) evaluate the effectiveness of interventions.

NACCHO strongly supports the development of integrated surveillance systems and data collection mechanisms that allow for analysis and dissemination of accurate local data, including but not limited to census tract, zip code, county, city, and region. In addition, NACCHO urges that local- and state-reported data in such systems be equally accessible to local, state, and federal jurisdictions. Data files should reside in electronic form at the LHD whenever local capacity permits and be designed to permit analysis of data elements by local staff to address local circumstances.

Justification

Because state and national data often do not identify potential health needs or trends of localities, each LHD must have the capacity to collect and analyze local data to monitor and improve the health of its community.

Epidemiology and surveillance capacities are essential to assuring the three core functions of public health at the local level: assessment, policy development, and assurance. The strategic assignment of epidemiology professionals to provide technical assistance and support to LHDs and the provision of epidemiologic training to LHD staff will enable the setting of appropriate population-based health metrics, ongoing improvement of public health response protocols and interventions, and improvement of community health outcomes.

Finally, national and state datasets often do not have specific local data, which limits their usefulness to LHDs. Data that can be disaggregated by census tract, zip code, county, city, and/or

region are integral to developing and implementing data-driven public health programs, interventions, and priorities.[1]

Record of Action
Adopted by NACCHO Board of Directors, November 7, 2004
Revison adopted by NACCHO Board of Directors, July 11, 2007

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[1] Luck J., Chang C, Brown EC and John Lumpkin J. Using local health information to promote public health: issues, barriers, and proposed solutions to improve information flow. Health Affairs. 2006;25:975-991.

Public Health
Prevent. Promote. Protect.

The Role of Local Health Departments

This fact sheet briefly describes what every person, regardless of where they live, can reasonably expect from their local health department (LHD). LHDs protect and improve community well-being by preventing disease, illness and injury and impacting social, economic and environmental factors fundamental to excellent health. The LHD is the foundation of the local public health system that comprises public- and private-sector health care providers, academia, business, the media, and other local and state governmental entities. Adapting to local circumstances, LHDs vary in the strategies and tactics used to protect and improve community well-being.

- ***Track and investigate health problems and hazards in the community.*** LHDs gather and analyze data on the community's health to determine risks and problems. This information drives specific programs and activities designed to control multiple threats: both communicable and chronic diseases; food, water, insect and other "vector-borne" outbreaks; biological, chemical and radiological hazards; and public health disasters.

- ***Prepare for and respond to public health emergencies.*** As a result of extensive and ongoing preparation, LHDs respond quickly and effectively to disease outbreaks and other public health events—they are intensively trained to respond to increases in the incidence of diseases, natural disasters, and acts of terrorism. They coordinate delivery of drugs, supplies, and provisions to victims and populations at risk. They keep the public informed and serve as the network hub for community hospitals, physicians, and other health care providers.

- ***Develop, apply and enforce policies, laws and regulations that improve health and ensure safety.*** Acting on their knowledge about their community, LHDs create data-driven policies to meet health needs and address emerging issues. They help craft sound health policies by providing expertise to local, state and federal decision makers. LHDs also inform individuals and organizations about public health laws while monitoring and enforcing compliance.

- ***Lead efforts to mobilize communities around important health issues.*** With local and state government agencies, businesses, schools, and the media, LHDs spearhead locally organized health promotion and disease prevention campaigns and projects. They galvanize the community to tackle disease prevention and personal health care needs. LHDs also educate and encourage people to lead healthy lives through community forums; public workshops and presentations; and public service announcements.

- ***Link people to health services.*** LHDs connect people with personal health services, including preventive and health promotion services, either in the community or as close to the community as possible. They also advocate for development of needed programs and services in underserved populations and continuously monitor the quality and accessibility of public health services.

- ***Achieve excellence in public health practice through a trained workforce, evaluation, and evidence-based programs.*** LHDs recruit and develop skilled workers with expertise in core public health competencies. They ensure that public health workers update their knowledge and skills through continuing education, training and leadership development activities. They regularly evaluate the effectiveness of all programs and activities using evidence-based standards and strive to adapt successful interventions from other communities.

Testimony to Board of Directors, Cook County Health and Hospitals System
Cook County Department of Public Health's Elimination of Family Case Management

July 23, 2008

By Robyn Gabel, Executive Director
Illinois Maternal and Child Health Coalition

Good morning, Mr. Chairman and members of the Board of Directors. Thank you for the opportunity to express our opinions and concerns regarding the Family Case Management program at Cook County Department of Public Health (CCDPH). Family Case Management (FCM) is an invaluable resource for Illinois' families that plays an important role in the prevention of negative birth outcomes such as prematurity, low birth weight, and infant mortality. Elimination of the FCM program in the CCDPH is of great concern in the face of disappointing trends in infant mortality and significant racial and socioeconomic disparities in birth outcomes. The United States ranks poorly among industrialized nations with an infant mortality rate (IMR) of 6.8/1,000 live births, what's more is that Illinois fairs worse with an IMR of 7.5/1,000 live births and an almost three-fold disparity in infant mortality between black and white infants.

FCM connects families with necessary resources such as timely access to healthcare and adequate nutrition thus promoting the health and well-being of infants and their families. Additionally, FCM allows for the early identification of and intervention in pregnancy-related and developmental problems, in turn reducing the occurrence of more serious and costly problems.

The expansion of the FCM program to provide services to all families receiving Medicaid has been critical in assuring access to needed services for low-income families. This is especially important given the association between socioeconomic status and birth outcomes.

We must express our disappointment with the Board's decision to eliminate FCM in the CCDPH. While we understand that a plan is being developed to reassign the thousands of families currently receiving services through the CCDPH's FCM program to community based organizations and FQHC's we are concerned that the numbers are too large and the transition time is too short to adequately ensure that all families are appropriately reassigned.

The elimination of FCM directly contradicts the Department's recommendation that the CCDPH focus on Health Promotion as one of its five areas of "core business". Prevention is a key element in Health Promotion and FCM is one of only a few long-standing programs dedicated to prevention. This move by the CCDPH can be construed as a lack of commitment by the health department to promote and monitor the health of the youngest and most vulnerable residents of Cook County. While we recognize the financial commitment required to maintain FCM, we are particularly concerned that this decision was primarily economic and failed to account for the societal benefits and cost effectiveness of prevention programs such as FCM. The Department stated in the July 7th memorandum that "when clients are not contacted or assessed, the potential for intervention to prevent a negative outcome is diminished". Clearly, they understand that the impact of FCM is intrinsically related to both the adequacy and timing of the intervention. This is especially relevant during pregnancy

because we know timing to be critical in healthy birth outcomes. We fear that this transition will affect both the adequacy and timing of the family case management program having a significant impact on the thousands of families currently receiving case management services through the CCDPH. With a monthly caseload of 21,500 the CCDPH cannot merely "redirect" families but has an obligation to develop and actively pursue a plan that will guarantee that families are not lost in the process nor their services delayed.

We are disappointed at the undemocratic manner in which this decision was reached. The Board failed to notify the public of the proposed change; furthermore, the final judgment was made impulsively and without regard for the serious implications of this decision. We hope that in the future, the public is allowed to have a voice in matters that are as vitally important as this one.

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CCDPH/ NNOC Nurse Rebuttal for the reduction/ elimination of services

The nurses at Cook County Department of Public Health feel that the elimination of the Family Case management Program would have devastating effects on already falling communities. Studies have shown that the public health nursing models for FCM has been more beneficial than non nursing models. With the elimination of this nursing model we will see an incline of a decreasing infant mortality rate, preterm deliveries, child abuse and neglect, teen pregnancy rates, and premature deaths related to inadequate health including postpartum depression. It requires skill professional nurses to identify many life threatening illness, impending health problems, and perinatal depression. Infant mortality rates are an indication of the health of an entire community.

Franklin Deleanor Roosevelt once said that the "*states paramount concern should be the health of its people.*" We feel the same about our residents of Cook County. We feel that this current administration at CCDPH has put numbers, profitability, and personal job security for the multiple layers of management over the health of the community. We have seen numerous reductions in services over the last ten years and this is yet another one while the upper management team continues to increase.

The organizational structure for the 2006-2008 years will show (2) directors of nursing, (2) regional directors, (4) district supervisors, (5) assistant nursing supervisors, and (1) director of special programs. A total of 14 in nursing upper management to supervise **64** nurses. This does not include (1) director over clinics to supervise 8-10 clinic nurses. This results in a nurse to management ratio of 5:1. If this is a microcosm for the entire bureau of health we can see why Cook County had a deficit of 500 million dollars and if not corrected will continue on a downward spiraling road. This is total mismanagement of funds.

Management will argue that some of those positions have been eliminated. Some have resigned or retired from the positions leaving them open, but these were recent and the argument to eliminate the program was based on the past budgets. A further study will show similar duplications in other areas through-out CCDPH.

The department recently added services from the Evanston Health Department, a hefty budget for the TB San (active tuberculosis cases has drastically decreased with no recent outbreaks), and were trying to force nurses to work as nutritionist in the WIC program on top of our high caseloads. We feel that these are strategies used as a safety net by creating more titles for directors due to these changes while planning all along to eliminate this much needed program (per Dr. Martin's statement dated 7/7/08, a **"2010 goal").**

In his memorandum dated 7/7/08 for CCDPH FCM service reduction, one of Dr. Martin's statements was that the nurses are carrying an average of 300 cases per nurse manager (this is 150 cases over the 150 per case manager recommended by IDHS) and were "unable to meet their performance standards for the period of 10/1/07-12/31/07".

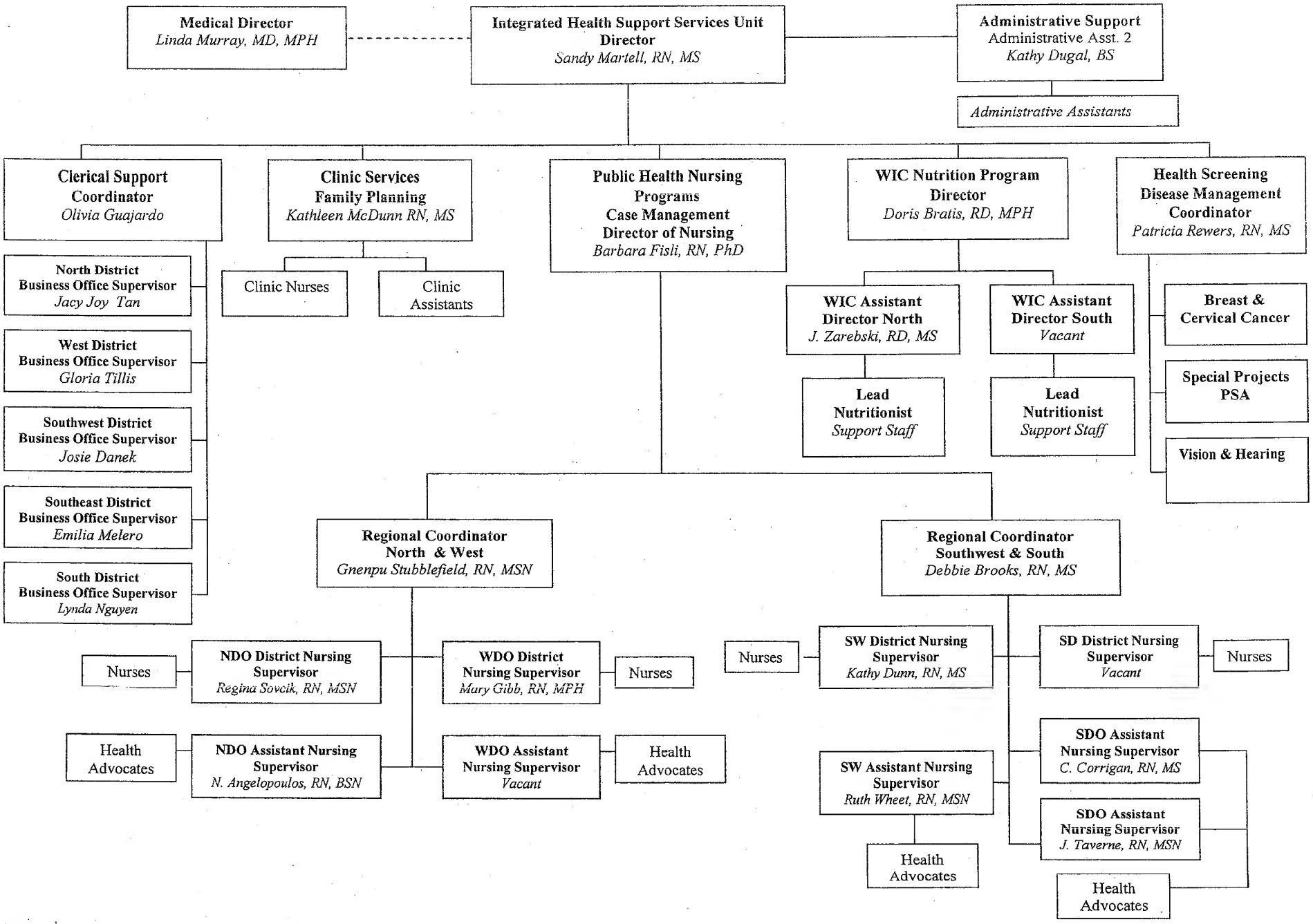
The displacement of 5 nurses during this same period who were instructed to stop home visits and prepare their charts for reassignment and closures had some affect on this outcome. *However, despite these high caseloads nurses where able to meet the performance standards for all other 3 quarters of the fiscal year and recently passed the states audit with certification for a 2 year period and were told that they did a good job.*

Nurses at CCDPH and NNOC feel that the elimination of this program will be a travesty for the community and will have a direct effect on the health of the population. We feel that other avenues could have been explored, especially since the department was awarded the 6 million dollar grant and have 2-3 millions already in a "deferred revenue account" which totals the 9 million needed to sustain the program at least until the end of the June 2009 fiscal year. Then hopefully a plan to sustain the program is ongoing.

Some nurses have been employed by CCDPH for over 20-30 years, and to have to learn about the elimination of this successful program and the elimination of their jobs from a newspaper article was disgraceful. Then for management to come out and read a statement offering the employee assistant program (EAP) was a total insult. Most of CCDPH programs/ grants are integrated, so these same nurses function in several different capacities and budgets. We are the backbone for implementing the agency grants.

We hope that this board/ committee take this matter into careful consideration because elimination of the FCM program and nursing positions will be the catalyst for a negative impact on the health of the community. In addition it will have a delayed affect on state and county budgets by increasing the cost of health care due to adverse health outcomes imposed on the population due to your decisions.

Submitted by:
Irene Hardy RN
CCDPH/ NNOC chief steward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Integrated Health Support Services Unit
Director
Sandy Martell, RN, MS
Administrative Support
Administrative Asst. 2
Kathy Dugal, BS
Administrative Assistants
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Business Office Supervisor
Lynda Nguyen
Clinic Nurses
Clinic
Assistants
WIC Assistant
Director North
J. Zarebski, RD, MS
WIC Assistant
Director South
Vacant
Lead
Nutritionist
Support Staff
Lead
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Debbie Brooks, RN, MS
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Supervisor
Regina Sovcik, RN, MSN
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Mary Gibb, RN, MPH
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Health
Advocates
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Vacant
Nurses
SW Assistant Nursing
Supervisor
Ruth Wheet, RN, MSN
SDO Assistant
Nursing Supervisor
C. Corrigan, RN, MS
SDO Assistant
Nursing Supervisor
J. Taverne, RN, MSN
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Advocates
Health
Advocates

My name is Irene Hardy; I have been a RN for 32 years and with Public health nearly 14 years. The nurses at CCDPH and through-out the bureau were very optimistic about this new Board of Director in hopes that you would make the real changes needed to put the focus back on the clients, finding was to improve the quality of care and to carry out the real mission of servicing the residents of Cook County. We are very disappointed in your decision to eliminate the Family Case management program in a single vote without reviewing data on the success of the program or hearing opposing statements on the need for this vital program.

The communities that will suffer the most will be the neediest areas. A large population that CCDPH service is minority communities with higher teen pregnancy rates. . African Americans and Hispanic have some of the highest rates of infant mortality in the country. Infant mortality rates are an indication of the health of the entire community.

While non nursing FCM models can coordinate services and give referrals. Skilled nurses can quickly identify impending problems; diagnose life threatening illness such as pre-eclampsia, GDM, placenta previa or perinatal depression in pregnant women as well as congenital, cardiac or respiratory problems in infants and children which leads to premature death. Early detection, intervention and health education is the key to good prognosis and decreasing healthcare cost with life long benefits.

We feel that the elimination of this program will be a travesty and have a direct affect on the health of the community. The county and state will see an increase in preterm deliveries, low infant birth rates, child abuse and neglect, teen pregnancy rates, and premature death related to late DX and treatment of illness and/ or perinatal depression.

We hope that this Board will reconsider this vote and we urge you to take some time to look at other avenues to sustain this essential program. We feel that if this board proceeds hastily with this decision it will be the catalyst to reverse all the gains obtained in lowering infant morality and preterm death and have a negative impact on entire communities.

We are baffled over the urgency to eliminate this program, since the nurses recently passed the states audit with certification over a 2 year period for up to 6 million annually. We fill that this 6 million and the 2-3 million in the deferred revenue account as referenced in Dr Martins' memorandum dated 7/7/08 for service reductions can at least sustain the program until the end of the 6/30/09 state fiscal year and stop the closure of active cases being imposed presently for infants over 6 months of age risking interruption of services and putting them at risk. This will give a less risky transition and the needed time to explore other options.

A program with such success at CCDPH in lowering infant mortalities and preterm deliveries for almost 20 years and affects over 21, 000 residents of Cook County surely deserves a second look before elimination. .

NATIONAL NURSES ORGANIZING COMMITTEE | CALIFORNIA NURSES ASSOCIATION

Testimony submitted to the Board of Directors of the
Cook County Health and Hospitals Committee, Wednesday, July 23, 2008
Frank Borgers, Ph.D., National Nurses Organizing Committee

NNOC believes the decision to eliminate the Family Case Management Program (FCMP) was made without a thorough review of the administration's case, and without adequate public discussion. Dr. Martin's memorandum to the Board of Directors (July 7, 2008), *by itself*, raises several urgent questions that should be explored before proceeding with FCMPs elimination.

1) Martin presents the elimination of FCMP as extremely urgent and warns that Board inaction would be very costly. However, Bureau administrators knew of the immediate financial crisis facing FCMP as early as March 3, 2008, and FCMPs systemic under-funding was recognized long before this. (Martin Memo, p. 2-3) *Given the alleged urgency why did Bureau leadership wait until July 11th to confront this crisis?*

2) The anticipated FY 2009 shortfall in Federal reimbursement - the trigger for FCMPs crisis - was $900,000. (Martin Memo, p. 1-2) *Is it not possible to identify efficiencies or other savings elsewhere in the $182m Bureau budget to cover this shortfall?*

3) Martin states that high caseloads have "contributed to the failure to meet performance standards" and that FCMP was "unable to meet their performance standards for the period of 10/1/07-12/31/07." (Martin Memo, p. 2) Martin does not account for the performance impact of the displacement of five case managers during this period. *Martin also fails to acknowledge that nurses met the performance standards for the other 3 quarters of 2007 and that FCMP passed the state's audit in early 2008 with certification for a 2 year period.*

While FCMP clearly suffers from inadequate state and federal funding and chronic nurse under-staffing, the entire Bureau and its mission face these challenges. NNOCs support and advocacy for the creation of the Board of Directors was based on the hope that this new body would craft more creative solutions to these challenges than the failed "tax or cut" approach of Cook County's administration over the last two years.

Eliminating FCMP raises obvious concerns regarding the impact of the elimination of FCMP on mothers and infants and ongoing efforts to reduce racial disparities in infant mortality. These concerns are discussed briefly below.

We urge the Board to consider the impact of their decision making *process* on County nurses and support staff. As discussed below, systemic failures of the Bureau and successive rounds of nursing cuts have taken a heavy toll on nurse morale. The elimination of FCMP and its case managers, without exploring creative alternatives, perpetuates this vicious cycle.

NNOC respectfully urges the Board to reconsider its vote in order to allow a thorough review of the administration's case.

Infant Mortality and the need for the Family Case Management Program: FCMP has had a case management program for medically high risk mothers and infants since 1945 and *currently serves approximately 21,500 clients per month.* Dr. Martin acknowledges that in the absence of the services provided by FCMP *"the potential for intervention to prevent a negative outcome such as a low birth weight infant, pre-term labor, and/or infectious disease is diminished."* (Martin Memo, p. 1)

While probably redundant for members of this committee, it must be recognized that US infant immortality rates are a disgrace for a country as wealthy as ours, that Illinois fares poorly in state comparisons, and even worse with regard to racial disparities.

As widely reported last week, following the release of the Commonwealth Fund's annual healthcare scorecard report[1], the US - at 6.8 deaths per 1,000 live births - continues to rank last among the eight industrialized countries that report infant mortality using the same methodology. US infant mortality is *more than double the leading countries* (2.8 to 3.1 deaths per 1,000 live births in Japan, Iceland, and Sweden in 2004).

Illinois continues to report mortality rates higher than the national average, at 7.5 deaths per 1,000 live births in 2004[2]. Black infant mortality in Illinois runs more than twice as high, at 15.7 deaths per 1,000 live births in 2004[3], more than three times the average mortality for West Europe, and the same or higher than rates in 19 Latin American and Caribbean countries, and 12 East European countries.[4]

It is hard to understand how the Board can justify elimination of FCMP given the urgent need to reduce infant mortality. At a minimum, NNOC would hope that the Board would first explore creative options for operational reform and financing of FCMP.

Registered Nurse Morale at CCDPH: The systemic failures of the Bureau and successive rounds of nursing cuts have taken a heavy toll on nurse morale which, in turn, has exacerbated County's poor record for nurse recruitment.

NNOCs recent survey of over 400 County RNs found that 82 percent said morale "has deteriorated over the past year." Of the 17 percent who said morale is "about the same," many would agree with a Stroger nurse who pointed out that morale "was depressed last year and it remains depressed." *Bureau wide findings are mirrored at CCDPH, with 33 out of 36 nurses reporting worsened morale over the past year.*

Systemic failures in patient care and scapegoating of RNs, a lack of respect and recognition for RNs, and a lack of faith in administration top the list of factors driving declining RN morale. (See fig.1) Workload stress and the ongoing uncertainties around job security weigh also heavily on County nurses.

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[1] The Commonwealth Fund, "Why Not the Best? Results from the National Scorecard on US Health System Performance, 2008," July 2008.
[2] US National Center for Health Statistics, National Vital Statistics Reports. v. 55, No. 19, August 21, 2007.
[3] ibid.
[4] US Census Bureau, Global Population Profile: 2002.

- *Due to decreased staffing and cut positions nurses continue to be held accountable for productivity, this impacts morale on an intense level.*
- *Due to uncertainty of funding for healthcare services, I feel all county health dept employees have suffered a decrease in morale.*
- *Fear of the unknown in terms of job security has demoralized County RN's.*
- *Lack of staffing overwhelms those working to keep up with work load*
- *Morale is at an all time low. CCDPH is short-staffed and will continue to be stressed with many forth-coming changes.*
- *Nurses are working endlessly with little or nothing to accomplish same goals as in the past.*
- *Overwhelming, over-stressed, over-worked & understaffed leading to emotional fatigue & physical maladies.*
- *RN morale has been greatly reduced overtime - the ability to practice what a REAL nurse function is has been greatly diminished.*
- *RN's feel scapegoated for all the county woes. Meanwhile, friends and family of administrators are getting jobs with little qualifications.*
- *TERRIBLE. So understaffed & poorly run by Administration.*
- *The employees at CCDPH are not respected, I think morale is at its lowest since I've been employed at CC.*
- *This administration encourages a style that wants staff to have such a low morale.*
- *Unsure of future at County.*
- *Unsure of future role of nursing.*

The elimination of FCMP and its case managers, without first exploring creative reforms, perpetuates the vicious cycle of chronic mismanagement, nurse under-staffing, and failing patient care, that is undermining RN morale at County.